Threshold Barriers to Title 1 and Title III of the Americans with Disabilities Act: Discrimination against Mental Illness in Long-Term Disability Benefits

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THRESHOLD BARRIERS TO TITLE I AND TITLE III OF THE AMERICANS WITH DISABILITIES ACT: DISCRIMINATION AGAINST MENTAL ILLNESS IN LONG-TERM DISABILITY BENEFITS

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I. INTRODUCTION .................................... 207
II. TYPICAL AMERICANS WITH DISABILITIES ACT LONG-TERM DISABILITY INSURANCE CASE ........................................ 208
III. SUMMARY OF RELEVANT REMEDIAL STATUTES ....................... 211
      A. Americans with Disabilities Act ................................ 212
      B. Title VII of the Civil Rights Act ................................ 214
      C. Rehabilitation Act ........................................... 215
      D. Employee Retirement Income Security Act .................... 218
      E. Age Discrimination in Employment Act ......................... 222
      F. Health Insurance Portability and Accountability Act ............ 223
      G. Mental Health Parity Act ...................................... 225
IV. BACKGROUND SOCIAL, ETHICAL, AND LEGAL ISSUES .................. 228
      A. Prevalence of Employer-Provided Health Insurance and Long-Term Disability Insurance ........................................ 228
      B. Nature of Long-Term Disability Insurance ....................... 230
      C. Prevalence of Mental Illness and Impact of Health and Disability Insurance Restrictions on Treatment .................... 234
V. TITLE I OF THE AMERICANS WITH DISABILITIES ACT ............ 247
      A. Language of the Statute ........................................ 247
      B. Parker v. Metropolitan Life Ins. Co. ........................... 248
         1. Facts ...................................................... 248
         2. Analysis: United States District Court for the Western District of Tennessee ........................................ 250
         3. Analysis: United States Court of Appeals for the Sixth Circuit ........................................ 251

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C. Supporting Title I Decisions

D. Conflicting Title I Decisions

E. Analysis of Title I Issues

VI. Employee Retirement Income Security Act and

Parker v. Metropolitan Life Ins. Co.

A. Analysis: United States District Court for the
Western District of Tennessee

B. Analysis: United States Court of Appeals for
the Sixth Circuit

VII. Title III of the Americans with Disabilities Act

A. Language of the Statute

B. Cases Related to Parker v. Metropolitan Life
Ins. Co.

1. Cases Limiting Title III to Physical
Structures

2. Cases Applying Title III More
Expansively

a. Circuit Courts

b. District Courts

C. Parker v. Metropolitan Life Insurance Co.

1. Analysis: United States District Court
for the Western District of Tennessee

2. Analysis: United States Court of Appeals
for the Sixth Circuit—Three-Judge Panel

3. Analysis: United States Court of Appeals
for the Sixth Circuit—En Banc Majority

a. Place of Public Accommodation

b. Goods and Services

c. Disparity Between Mental and Physical
Disability Benefits

4. Analysis: United States Court of Appeals
for the Sixth Circuit—En Banc Dissents

D. Analysis of Title III Issues

1. Ambiguity of the General Rule of Title III

2. Department of Justice Regulations

3. Department of Justice Technical Assistance
Manual

4. Resolving the Ambiguity

VIII. Conclusion
I. INTRODUCTION

In August 1997, the United States Court of Appeals for the Sixth Circuit decided *Parker v. Metropolitan Life Insurance Co.* in a way that places it in conflict with a 1994 decision of the First Circuit, *Carparts Distribution Center, Inc. v. Automotive Wholesaler's Ass'n of New England.* The Sixth Circuit decision is notable not only because of the conflict it creates, but also because it was a closely decided en banc decision that reversed the holding of the three-judge panel, affirmed the district court, and contained two dissents. The En Banc Sixth Circuit's decision creates major threshold obstacles to the protections afforded by the American's with Disabilities Act (ADA) for people with long-term, serious mental illnesses. Such people cannot pass the court's threshold issues involving whether a totally disabled plaintiff has standing to sue under Title I and whether an insurer who enters into a contract with an employer is a public accommodation subject to the requirements of Title III. Consequently, substantive issues such as whether a disparity in long-term disability insurance coverage between mental and physical disabilities constitutes illegal discrimination, or whether the disparity is a subterfuge to evade the policy of the ADA, are not reached.

Using the *Parker* decisions as pivotal cases, this article will discuss whether a person who receives employer-provided long-term disability insurance which provides inferior benefits for a long-term mental disability, compared with a physical disability, should be permitted to proceed against his employer under Title I of the ADA and/or against the insurer under Title III of the ADA. It will argue that, contrary to the weight of current authority, Title I allows totally disabled employees to challenge the disparate terms of long-term disability benefits. The article will also argue that currently conflicting authority should be resolved to hold that an insurer who provides disparate long-term disability benefits is in violation of Title III of the ADA, even if the benefits are provided through the employer, rather than directly to the insured, because the insurer is a public accommodation under the ADA.

Any discussion of the ADA presents an organizational challenge not only because of the complex structure of the Act itself, but also because the ADA implicates other complex federal remedial schemes such as the Employee Retirement Income Security Act (ERISA) and the Rehabilitation Act. The

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2121 F.3d 1006 (6th Cir. 1997) (en banc).

337 F.3d 12 (1st Cir. 1994).


social policy implications of the issues under discussion in this article are complex and at times even contradictory, as is perhaps unavoidable.9

Part II outlines a typical case in which the employer provided inferior long-term disability benefits to those with mental disabilities. The purpose of Part II is to provide the reader with a map of the procedural and threshold issues facing the typical claimant in such a situation.

Part III provides brief summaries of other remedial statutes that are related to, or that have an impact on, interpretation of the ADA. Part III includes descriptions of two statutes passed in 1997 and discusses whether either offers any assistance to the plaintiff in the typical case under discussion in this article. Part III is not intended to provide exhaustive analysis of the ways in which courts have construed the various statutes. It is only intended to provide a glimpse of the complexity of the issues raised here.

Part IV provides information about background social, ethical and legal issues that are implicated in the typical case. For example, the importance of the fact that most people who have health or long-term disability insurance receive it as a benefit of employment must not be underestimated. Access to mental health care is being driven by workplace values and biases.

Part V addresses the Title I issues raised in the typical case. The various opinions written in Parker will be explained, as will supporting and conflicting decisions from other federal courts. Part V ends with an analysis of Title I issues and argues that totally disabled employees should have standing to sue their employers for discrimination in long-term disability insurance benefit matters.

Part VI trac es Parker’s ERISA claim through the courts. This brief section demonstrates why ERISA has not been successful in providing employees with meaningful review of discriminatory treatment in the context of insurance benefits.

Part VII addresses the Title III issues raised in the typical case. The language of the statute will be examined and prior cases, some interpreting Title III broadly and some interpreting it narrowly, will be discussed. A detailed discussion of the several Parker opinions will be followed by an analysis of Title III issues which urges a broad reading of Title III.

II. TYPICAL AMERICANS WITH DISABILITIES ACT LONG-TERM DISABILITY INSURANCE CASE

The Americans with Disabilities Act (ADA) prohibits discrimination against individuals on the basis of disability. Title I prohibits discrimination in employment. Title III prohibits discrimination by public accommodations. Title


V contains miscellaneous provisions, including one that provides a safe harbor for disability-based disparities in insurance coverage that are based on actuarial calculations and that are not a subterfuge to evade the purposes of the ADA.

While there are numerous ways in which facts can combine to produce claims under Title I and Title III of the ADA, this article focuses on one typical fact pattern that has recently produced conflicting opinions in the federal courts. The facts of such typical cases begin with a non-disabled employee who receives long-term disability insurance as a benefit of employment.10 The disability insurance may be self-funded11 or insured,12 and may be paid for entirely by the employer, or the employee may make contributions.13

10Often, of course, the employee may also receive health insurance as a benefit of employment. Coverage for mental illness in these policies is often limited by annual or lifetime caps while coverage for physical illness is either unlimited or has far greater coverage limits.

Several cases address the question of whether such disparate treatment of physical and mental illnesses in health insurance contracts is a violation of the ADA. Generally, inferior health insurance coverage of mental illness has been held not to be discrimination under the ADA. EEOC regulations approve such disparities under certain situations. EEOC: INTERIM POLICY GUIDANCE ON ADA AND HEALTH INSURANCE, June 8, 1993, reprinted in Americans with Disabilities Act Manual (BNA) at 70:1051-1056, Fair Empl. Prac. Manual, at 405:7115. For this reason, plaintiffs who have a continuing mental illness, but limited health insurance coverage for mental illnesses, argue their illnesses are organic in origin and so within the physical illness coverage category. This argument usually fails.

The category of insurance at issue in a particular case (health or disability) does not appear to be a decisive fact in the existing case law. What does make a difference is whether the employee's mental disability is totally disabling. A totally disabled employee is no longer a qualified individual with a disability entitled to protection under Title I of the ADA.

This article shows that health insurance and disability insurance differ in significant ways. The courts should take these differences into account.

11A plan is self-insured—sometimes called "self-funded"—when the employer, rather than an insurance company, assumes total financial responsibility and risk for providing benefits. . . . Self-insuring allows employers flexibility in designing and administering health care plans because ERISA preempts such plans from state-imposed benefit requirements. . . . In this way, state laws regulating the insurance industry prohibiting such discrimination cannot reach them.


12"An insured health insurance plan is one that is purchased from an insurance company or other organization, such as an HMO. . . . Insured health insurance plans are regulated by ERISA and state law while self-insured plans are typically subject only to ERISA." Id. at 230 n.102.

13Often the employee has the option to obtain expanded coverage by making contributions to a basic plan paid for by the employer.
The employer-provided disability insurance creates two classifications of disabling conditions: physical disorders and mental (or mental/nervous) disorders. It also creates two levels of coverage. Employees who are disabled as a result of physical disorders receive disability benefits until age 65, at which time social security takes over. Employees who are disabled as a result of mental disorders receive disability benefits for a shorter period of time (often two years).

The employee develops a mental illness that eventually becomes so debilitating that the employee is no longer able to work. The long-term disability insurance then begins to pay the employee under the terms of the plan. The employee, who cannot work, who may no longer be covered by health insurance, and who is eligible only for limited disability benefits, exhausts administrative remedies by filing a complaint with the EEOC and eventually sues the employer and the insurance company under Title I and Title III of the ADA challenging the disparity of coverage between physical and mental disability benefits in order to win the right to receive benefits until age 65.

With respect to the Title I claim, the defendants file a Rule 12(b)(6) motion to dismiss arguing that the protections of Title I are available only to a qualified individual with a disability. A person whose disability makes him unable to work is not a qualified individual and thus is not entitled to the protections of Title I. Though there is some authority to the contrary, to date the weight of authority is that the motion will be granted.

With respect to the Title III claim, the insurer files a Rule 12(b)(6) motion to dismiss on the ground that the insurer is not a public accommodation. The

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14 See infra Parts V-VII for case examples and discussion.

15 Health insurance benefits may initially cover the employee for less severe, non-disabling mental illness or even for a physical illness.

16 Again, whether an employee who is receiving long-term disability benefits can also receive health insurance benefits depends on the contracts provided by the employer. Some employers offer both; in such cases the distinction between health insurance (which is intended to cover medical expenses) and disability insurance (which is intended to provide wage-replacement) is illustrated. See infra Part IV(B) for discussion of the differences between disability insurance and health insurance.

17 The complaint will probably be filed in a United States District Court because the ADA claims bring ERISA preemption into play. Some recent cases have been filed in state courts, where plaintiffs have tried to avoid ERISA by alleging state claims such as intentional and negligent infliction of mental distress. The cases which have been reported have been removed to federal court by the defendants. The state tort claims are usually found to be preempted by ERISA and dismissed. See, e.g., Carparts, 37 F.3d 12 (1st Cir. 1994); Schroeder v. Connecticut Gen'l. Life Ins. Co., Civ. Action No. 93-M-2433, 1994 WL 909636 (D. Colo. Apr. 22, 1994).

18 Under some circumstances the motion to dismiss will be treated and disposed of as though a Fed. R. Civ. P. 56 motion for summary judgment. See Fed. R. Civ. P. 12(b).

19 The employer is probably not subject to Title III because only Title I addresses the terms and conditions of employment. The insurer may be subject to Title I if it comes
argument is that since a public accommodation is a physical place, an insurer who provides a contract to an employer is not a public accommodation vis-a-vis the employee. Authority is divided on this issue. Some courts have extended Title III to cover insurers while others have limited it to physical places.

These threshold issues have frequently barred disabled employees from the opportunity to persuade courts that the disability-based disparity is impermissible discrimination under either Title I or Title III. Only if the employee gets past these thresholds can he proceed to prove that the disparity in the insurance contract is an impermissible discrimination on the basis of disability.

If these thresholds are crossed, an employee still faces hurdles on the substance of the discrimination claim. Defendants argue that even if they are subject to either Title I or Title III, the disparate treatment of mental and physical illness is permitted by the safe harbor provisions of Title V of the Act so long as the goal of the disparity is not a subterfuge to evade the Act. Defendants argue that the term subterfuge should be defined consistently with the way in which it has been interpreted in prior cases involving other remedial statutes such as the Age Discrimination in Employment Act and the Rehabilitation Act. In these earlier cases, subterfuge required a showing of specific intent to subvert the Act's purpose. Employees will argue that the term subterfuge should be defined consistently with Equal Employment Opportunity Commission and Department of Justice regulations which require an actuarial demonstration of non-discriminatory consequences, but that intent is not required.

As can be seen from this brief tracking of a typical case, an employee faces difficult threshold issues to his claim for protection of the ADA. An employee who has developed a mental disability often finds it impossible to address the merits of the discrimination claim because (1) he does not qualify under Title I as an employee and (2) the insurer does not qualify under Title III as a public accommodation. The remainder of this article elaborates upon the problem posed by this typical case.

III. SUMMARY OF RELEVANT REMEDIAL STATUTES

The ADA amends several pre-existing statutory schemes. When a claim is made under the ADA some of these other statutes come into play through statutory direction, similarity of statutory language, or by analogy to decisions made in earlier cases addressing similar issues. Remedial statutes have recently been enacted which address some of the same concerns as does the ADA.

Following are brief summaries of the ADA and some of the most relevant prior statutes. Short descriptions of the Health Insurance Portability and Accountability Act and the Mental Health Parity Act, which were enacted in

within the statutory definition of employer. See David Monoogian, With Suits Mounting, Courts Face the Question of Whether a Managed Care Organization Can Be an Employer Under the Americans with Disabilities Act, NAT'L L. J. Mar. 17, 1997 at B6.
1997, are also included, together with projections of whether this new legislation will assist people with serious long-term mental disabilities.

**A. Americans with Disabilities Act**

Congressional findings supporting enactment of the ADA recount the substantial number of persons with a disability who experience discrimination and the breadth of the discrimination they experience.

The Congress finds that some 43,000,000 Americans have one or more physical or mental disabilities, and this number is increasing as the population as a whole is growing older; historically, society has tended to isolate and segregate individuals with disabilities, and, despite some improvements, such forms of discrimination against individuals with disabilities continue to be a serious and pervasive social problem; . . . individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion, the discriminatory effects of architectural, transportation, and communication barriers, overprotective rules and policies, failure to make modifications to existing facilities and practices, exclusionary qualification standards and criteria, segregation, and relegation to lesser services, programs, activities, benefits, jobs, or other opportunities; [they] are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society, based on characteristics that are beyond the control of such individuals . . .

The ADA proclaims "the Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals." In pursuit of its purpose the Act is "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities; [and] to provide clear, strong, consistent, enforceable standards addressing discrimination against individuals with disabilities."

The ADA was intended to correct some of the disappointments of older legislation such as ERISA, the Age Discrimination in Employment Act

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21 See id. § 12101(a)(8).

22 See id. § 12101(b)(1).

23 See id. § 12101(b)(2).

24 For example, the failure of ERISA to protect employees is noted by one commentator who points out that today "[t]he EEOC, under the ADA rather than ERISA, is attempting to address ERISA's flaws by claiming that disability-based distinctions in health plans are prohibited unless the employer can prove that the distinctions are, in fact, not discriminatory or that a legitimate business justification is the basis for such
(ADEA), and the Rehabilitation Act. For example, while the Rehabilitation Act had taken some steps toward providing equality to those in federally-funded employment, "[a] simple amendment of the Rehabilitation Act could not suffice" because "[t]he drafters of the ADA recognized the need for a more comprehensive bill to prohibit discrimination in all areas of life and to send a clear message that this discrimination was no longer acceptable."

At the time it was enacted, the intent of the ADA was considered a significant advancement of the civil rights of disabled individuals. However, the shortcomings of the Act were noted from the outset, particularly for those with mental disabilities. It is clear that the ADA specifically protects those with mental illnesses to the same extent that it protects those with physical disabilities. On the other hand,


The conflict between the courts and Congress on the meaning of the word subterfuge has been the subject of commentary. One commentator notes, "Although the language of section 4(f)(2) of the ADEA is similar to the ADA's section 501(c), the plain language of the ADA and Congressional reaction to the ADEA cases clearly indicate that the standard articulated in these cases does not apply to section 501(c)." Monica E. McFadden, Insurance Benefits Under the ADA: Discrimination or Business as Usual? 28 TORT & INS. L.J. 480, 490 (1993).

Id. at 499.

Id.


For example, one commentator remarked, "The passage of the Americans with Disabilities Act (ADA) raised high hopes for some and deep concerns for others. Amid the flurry of publicity and public attention to the ADA, very little has been said about a significant portion of the beneficiaries of the act, those with mental disabilities." Margaret Hart Edwards, The ADA and the Employment of Individuals with Mental Disabilities: Americans with Disabilities Act, 18 EMPLOYEE REL. L.J. 347, 347 (1992-93). Criticism of the regulations supporting the ADA was also prompt. See, e.g., Arney, supra note 28 (proposed regulations offered little guidance in fulfilling the purpose of the ADA).

See 42 U.S.C. § 12101(a)(1) (1990). With respect to equality of benefits in employer-provided health insurance plans, "the miscellaneous provisions set forth in Title V of the ADA relating to insurance muddy the waters." Brian D. Shannon, Paving the Path to Parity in Health Insurance Coverage for Mental Illness: New Law or Merely Good
Even though there is an enormous number of individuals with mental disabilities, there is little legislative history discussing them, and negligible guidance within the Act itself . . . Employers—most of whom are relatively unfamiliar with mental disabilities—now face the task of avoiding discrimination and engaging in reasonable accommodation of individuals with mental disabilities.\(^\text{31}\)

As it has been interpreted by the courts, it has become evident that the ADA has been ineffective in eliminating discrimination against those with mental illness in the area of insurance and disability benefits.\(^\text{32}\)

Of particular interest are Titles I, III and V of the ADA.\(^\text{33}\) Title I prohibits discrimination against disabled individuals in employment settings.\(^\text{34}\) It is enforced by the Equal Employment Opportunity Commission (EEOC), which has promulgated regulations, interpretive guidance and technical assistance manuals to accomplish that task. Title III prohibits discrimination against disabled individuals by public accommodations.\(^\text{35}\) It is enforced by the Department of Justice which also has issued regulations and technical assistance manuals. Title V contains miscellaneous provisions related to insurance that apply to Title I and Title III.\(^\text{36}\)

**B. Title VII of the Civil Rights Act**

Title I of the ADA specifically incorporates the powers, remedies, and procedures of Title VII of the Civil Rights Act.\(^\text{37}\) Title VII's purpose of eliminating discrimination in employment is very similar to the purpose of the ADA. Both are intended to eliminate discrimination against individuals. The two Acts have language and terms in common.\(^\text{38}\) It is generally held that Title I ADA claimants must exhaust Title VII administrative remedies before filing

\(^{31}\) Edwards, supra note 29, at 347.

\(^{32}\) See, e.g., Shannon, Parity in Health Insurance, supra note 30.

\(^{33}\) The ADA contains five titles. Title II prohibits discrimination against disabled individuals by public services. Title IV is related to telecommunications services for hearing impaired individuals.


\(^{35}\) See id. § 12181.

\(^{36}\) See id. § 12201. Various sections of Title V also apply to Titles II and IV of the ADA.

\(^{37}\) See id. § 12117.

\(^{38}\) See, e.g., Gonzales v. Garner Food Services, Inc., 89 F.3d 1523, 1532-34 (1996) (Anderson, J., dissenting) (The Title VII interpretation of the term "employee" should apply to Title I claims).
a complaint. These connections between Title VII and Title I of the ADA have led to broad reliance on Title VII cases in interpreting terms used in Title I.

C. Rehabilitation Act

The Rehabilitation Act of 1973 was intended to "develop and implement, through research, training, services, and the guarantee of equal opportunity, comprehensive and coordinated programs of vocational rehabilitation and independent living for individuals with handicaps in order to maximize their employability, independence, and integration into the workplace and the community." Section 504 prohibits discrimination against disabled persons who are employed in programs which receive federal funds. While the success of the Rehabilitation Act in achieving these goals has been described

39 The procedure is summarized:
Individuals seeking redress under Title I of the ADA are required to bring actions through the equal employment opportunity commission administrative complaint resolution procedures. The EEOC will first attempt conciliation after a complaint has been investigated. Only after conciliation has failed will the EEOC pursue a civil action through the courts. The EEOC may also provide the complainant with a "letter of right to sue." Only after administrative remedies through the EEOC have been exhausted may the complainant seek redress in the courts.

40 For example, there has been debate whether Title VII standards should be used to determine whether discrimination has been established under Title I. See McFadden, supra note 25. McFadden argues that application of Title VII standards would result in unintended expansion of liability under the ADA.
Title VII is an absolute ban on discrimination, with no provisions on insurance and no cost-justification test. The ADA has a specific provision on insurance and specifically allows cost-justification though its business necessity and undue burden defenses. In addition, a complete ban on statistical extrapolation in the manner of Title VII would fundamentally alter the nature of insurance or benefit administration. The ADA cannot be interpreted to permit these consequences, given both section 501(c) and the cost-justification test. Thus, the Title VII standard cannot be the standard of review for the ADA.
Id. at 495.


43 A detailed and interesting history of federal disability law, including the Vocational Rehabilitation Act and the Rehabilitation Act of 1973, is recounted in Drimmer, supra note 28.
as "less than spectacular,"44 it is recognized as the first step in guaranteeing the civil rights of disabled employees.45

The Rehabilitation Act is important to an understanding of the ADA for at least two reasons. First, the legislative history of the ADA shows that the drafters expected the Rehabilitation Act to inform understanding of the ADA. It also shows that the ADA was intended to remedy the Rehabilitation Act's failure to address the problems of persons with a disability.46 Consequently, sections of the ADA reflect or copy sections of the Rehabilitation Act. For example, Title I of the ADA, which prohibits discrimination in employment, incorporates the concepts of qualified individuals with disabilities and of undue hardship which were developed under the Rehabilitation Act. Some degree of accommodation of qualified disabled employees, limited by financial hardship on the employer, is required by both the Rehabilitation Act and the ADA. The Rehabilitation Act is enforced by the Department of Health and Human Services, which has promulgated regulations interpreting the Act. These regulations influence the EEOC when it developed regulations for Title I of the ADA.47 Regulations interpreting Title III refer directly to the Rehabilitation Act, stating that the ADA is not to be construed to apply a lesser

44Note, Employment Discrimination Against the Handicapped and Section 504 of The Rehabilitation Act: An Essay on Legal Evasiveness, 97 HARV. L. REV. 997 (1984). The author of this note attributes the failing to be the Act's delegation of responsibility for choice [to] courts and administrative agencies [leav- ing] them to make ad hoc selections from among competing concep- tions of discrimination . . . As a result of this congressional default, handicapped persons and their actual or potential employers remain without meaningful guidelines for interaction. In addition, by convey- ing the false impression that it addresses the issues, the statute defuses agitation and inhibits political debate.

Id. at 997.

45One commentator elaborates upon the relationship between the Rehabilitation Act and the ADA:

The drafters of the ADA recognized the need for a more comprehen- sive bill to prohibit discrimination in all areas of life and to send a clear message that this discrimination was no longer acceptable. A simple amendment of the Rehabilitation Act could not suffice, given the number of arenas to be addressed. But the logic and language of the Rehabilitation Act, which had been tested and interpreted by the courts and which was effective in ending some discrimination against the disabled, pro- vided excellent building blocks. The disabled community also believed that codifying the logic of the Rehabilitation Act and the agency-created cost-justification test in the ADA insured the gains made as a result of the Rehabilitation Act would not be lost or called into question.

Mcfadden, supra note 25, at 497.

46Drimmer, supra note 28.

47Arney, supra note 28, at 526 n.34.
standard than the earlier Act, and that the ADA does not affect the obligations imposed under Section 504 of the Rehabilitation Act.\footnote{48}{C.F.R. § 36.102 (1991).} 

Second, cases decided under the Rehabilitation Act have been relied upon as authority for cases decided under the ADA. Perhaps the most important Rehabilitation Act decision, for purposes of the issues considered in this article, is \textit{Alexander v. Choate},\footnote{49}{49469 U.S. 287 (1985).} which reversed a decision by the Sixth Circuit. The Sixth Circuit had held that Tennessee’s modification of Medicaid benefits, that reduced the number of inpatient hospital days to be paid each year, was a violation of the Rehabilitation Act because the modification would have a disparate impact on disabled persons. The modification would have hurt handicapped hospital users more than nonhandicapped users.\footnote{50}{"Statistical evidence . . . indicated that in the 1979-1980 fiscal year, 27.4\% of all handicapped users of hospital services who received Medicaid required more than 14 days of care, while only 7.8\% of nonhandicapped users required more than 14 days of inpatient care." \textit{Id.} at 290.} The United States Supreme Court rejected both the argument that the change was discriminatory because it would have a disproportionate effect on the handicapped and the argument that any annual limitation would be discriminatory because it would be likely to disproportionately effect the handicapped.

While under some circumstances disparate impact might result in violation of the Rehabilitation Act, not every disparate impact is a violation. The Supreme Court reasoned that:

\begin{quote}
The new limitation does not invoke criteria that have a particular exclusionary effect on the handicapped; the reduction, neutral on its face, does not distinguish between those whose coverage will be reduced and those whose coverage will not on the basis of any test, judgment, or trait that the handicapped as a class are less capable of meeting or less likely of having.\footnote{51}{\textit{Id.} at 302.}
\end{quote}

In \textit{Alexander}, the Court noted that most discrimination against the handicapped was not intentional, but the result of neglect. "\textit{[M]uch of the conduct that Congress sought to alter in passing the Rehabilitation Act would be difficult if not impossible to reach were the Act construed to proscribe only conduct fueled by discriminatory intent.}\footnote{52}{\textit{Id.} at 296-97.} The Court also discussed the issue of access of Tennessee Medicaid patients to medical care. It found that "\textit{[N]othing in the record suggests that the handicapped in Tennessee will be unable to benefit meaningfully from the coverage they will receive under the 14-day rule. . . . The reduction in inpatient coverage will leave both}
handicapped and nonhandicapped Medicaid users with identical and effective hospital services. The Court emphasized that:

To conclude otherwise would be to find that the Rehabilitation Act requires States to view certain illnesses, i.e., those particularly affecting the handicapped, as more important than others and more worthy of cure through government subsidization. Nothing in the legislative history of the Act supports such a conclusion.

This idea—that a rule or contract term does not amount to unlawful discrimination if it affects disabled and non-disabled persons equally—has been important in those ADA cases in which a plaintiff has been able to reach the merits of the discrimination claim.

D. Employee Retirement Income Security Act

The Employee Retirement Income Security Act of 1974 (ERISA) was enacted to protect employees' rights to employer-provided pension plans and welfare benefit plans by requiring uniformity in the administration of benefit plans. While pension plans are comprehensively regulated under ERISA, "only the reporting, disclosure, fiduciary duty, and continuation of coverage rules apply to health plans." A significant feature of ERISA is a broad preemption clause which preempts all state law insofar as it relates to employee benefit plans, including state tort law, which is often favorable to disabled claimants.

53Id. at 302.
54Choate, 469 U.S. at 303-04.
58Because ERISA exclusively governs almost any claim relating to an employee benefit plan, workers are often denied the chance to seek relief under more protective state, and in some cases, even federal, laws. Preemption of pension issues makes sense, since states have no clearly stated public policy interest in the development and protection of deferred compensation. But wrongful discharge and discrimination issues have become matters of great interest and mature reflection by state courts and legislatures. The Congressional goal of having a uniform body of law relating to those issues should not obviate the rights states have given to their citizens.


See also, Robert L. Roth, Recent Developments Concerning the Effect of ERISA Preemption on Tort Claims Against Employers, Insurers, Health Plan Administrators, Managed Care Entities, and Utilization Review Agents, 8 HEALTH LAW. No. 7 at 3 (1996); David Henry Sculinick, HMO Liability and ERISA Preemption for Medical Malpractice, 8 HEALTH LAW. No. 7 at 8 (1996).
ERISA has generally been applied to limit remedies available to employees who have been wrongly denied benefits due under an employer-provided plan. Thus, extra-contractual damages such as pain and suffering or punitive damages are not available. 59

ERISA does not regulate the content of health or disability plans, though it does prohibit discrimination in employee benefit plans. Its impact on health or disability plans is limited to providing a cause of action based on retaliation against the employee for exercising his rights to the benefit or for wrongful denial of benefits under the terms of the plan.

Many commentators believe that ERISA, which was intended to be a pro-employee measure, has become a tool through which employers have successfully limited employees’ access to courts and to meaningful remedies, especially in the area of denial of health care benefits. 60 Insofar as the ADA was intended as a modest cure for this result, failure was predicted. 61

59 See cases collected at Robert Armand Perez, ERISA Preemption: Denying Employees’ Rights to Benefits, TRIAL, May 1997, at 72, 76 n.34.


60 Workers who rely on health benefits offered by their employers have discovered they are often protected only until they get sick...[T]he safeguards the drafters incorporated into ERISA have eroded over the past 18 years through a series of Federal court decisions. Today’s workers... actually have fewer rights to their benefits than they had prior to the enactment of ERISA.


“ERISA has been less successful in dealing with... medical benefit plans...[F]ederal courts are fashioning rules that allow employers to reduce or terminate health benefits to employees when the employees need these benefits the most: after they have been diagnosed with a costly disease...” Id.

See also, Morrison, supra note 59. But see Flannery, supra note 11.

61 See generally Flannery, supra note 11; Schmall, supra note 58; Butler, supra note 24.
ERISA is implicated in the matters raised by this article in the following ways. First, in the typical case proposed in Section II of this article, an employee who is mentally disabled is denied long-term disability benefits equivalent to those received by employees with physical disabilities. In a suit to secure equal benefits, the employee may claim intentional or negligent infliction of mental distress. Such claims are state tort claims related to an employee benefit plan and are thus preempted by ERISA. These claims are dismissed by the courts or even by the employee.

A second way ERISA is implicated is that sometimes the aggrieved employee claims that his disability has been wrongly classified as a mental disability (for which benefits are paid for only a limited period) when it should properly be classified as physical disability (for which benefits are paid until age 65). The employee here asserts the claim that the plan administrator wrongly denied him benefits to which he was entitled. While wrongful denial of benefits is a claim authorized by ERISA, if the terms of the employee benefit plan retain discretion in the administrator to make determinations of eligibility for benefits, the denial of eligibility will not be overturned unless the administrator's decision is arbitrary and capricious. This high standard of review may be insurmountable by the employee.

A third way ERISA is implicated in the ADA is by possible analogy to the ERISA case, McGann v. H & H Music Co. McGann was an employee of the defendant and received health insurance benefits as a benefit of employment. The plan provided a one million dollar limitation on benefits for all illnesses. McGann contracted AIDS and filed claims for benefits. Thereafter, his employer modified the benefit plan to place a five thousand dollar limit on AIDS claims while maintaining the million dollar maximum lifetime benefit for other serious illnesses. McGann filed a complaint under Section 510 of ERISA which makes it unlawful to "discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan, . . . or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan." Section 510 requires the employee to prove the employer had a specific intent to deprive him of the benefits which he claims.

The Fifth Circuit held that the record failed to show that McGann's employer was motivated other than by a desire to maintain financial stability. The court found that there was nothing to show a specific intent to discriminate against McGann, even though McGann was the only employee with AIDS at the time.
of the plan’s modification. The employer’s modification of the benefit plan was not discriminatory because the limitation it imposed affected all employees equally. All employees—those who already had contracted AIDS and those who in the future could contract AIDS—were subject to the five thousand dollar cap on AIDS-related expenses.

*McGann* received extensive critical commentary, yet has been "universally adopted as the definitive interpretation of the antidiscrimination provision" in ERISA. Thus, *McGann* approved the concept of disparity of benefits for certain large classes of disabled individuals.

*McGann* demonstrates that, prior to the effective date of the ADA, the law governing self-funded group health insurance freely permitted sharp distinctions in coverage with no enforcement of a fair discrimination principle (the *McGann* court regarded as insignificant the fact that catastrophic illnesses other than AIDS continued to be covered).

It is unclear whether *McGann* is overruled by the ADA, or whether Title V, which countenances risk classification in insurance benefits that is not a subterfuge, endorses it. "Unfortunately, the Baroque structure of the ADA in this regard precludes a definite answer." The issue has important implications to those with mental illnesses whose long-term disability insurance provides inferior benefits for mental illness.

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66 See, e.g., Butler, *supra* note 24. ("As McGann illustrates, ERISA has become a pro-employer statute that provides little, if any, protection from reliance on illusory benefits to the approximately 150 million people covered by ERISA health benefit plans." *Id.* at 1227). See also Schmall, *supra* note 58.


68 Id.

69 One commentator reasons:

Had the ADA been drafted without section 501(c), the answer would have been clear: the treatment suffered by McGann constituted disparate treatment, "because of a disability," in the "terms, conditions, and privileges of employment." Therefore, *McGann* would be overruled. Had section 501(c) been included, but without the final clause forbidding its use "as a subterfuge to evade the purposes" of Title I, the result would have been the opposite (*McGann* is upheld), but equally clear. Under these circumstances, section 501(c)(3) would have created a safe harbor for the ERISA-insulated, unreviewable risk segmentation at issue in *McGann*. The inclusion of the final clause in section 501(c), prohibiting "subterfuge," however, leaves the issue unsettled.

*Id.* at 353-54.

70 *Id.* at 353.
E. Age Discrimination in Employment Act

The Age Discrimination in Employment Act (ADEA)\(^7\) prohibits discrimination "[a]gainst any individual with respect to his compensation, terms, condition or privileges of employment, because of such individual's age."\(^2\) Both the ADEA and the ADA apply to employee benefit plans.\(^7\) Both prohibit subterfuge to evade the purposes of the Act.\(^7\) Both Acts allow an employer to use actuarial defenses to justify disparate treatment in health benefits.\(^7\)

The meaning of the term subterfuge under the ADEA was interpreted in Public Employees Retirement System of Ohio v. Betts.\(^7\) In that case, the state retirement system provided lower benefits for workers who were older than sixty years who retired due to a disability than it provided for workers who were older than sixty who retired due to a disability. Plaintiff and the EEOC claimed that the distinction violated the ADEA. The United States Supreme Court disagreed. The Court held that the employee could not show the specific intent required to prove an illegal subterfuge because, at least in part, the benefit standards were in place before the enactment of the ADEA.\(^7\) Betts also affirmed the holding in United Air Lines v. McMann,\(^7\) an earlier ADEA case, which defined subterfuge as "[a] scheme, 

\(^7\)See ADEA subterfuge provision at 29 U.S.C. § 623(f)(2)(A) and ADA subterfuge provision at 42 U.S.C. § 12201(c).
\(^7\)29 C.F.R. § 1625.10(a)(1)(1988). "The ADEA allows an employer to justify differentiation in health benefits that correspond to age if the lower benefits are mandated by, and proportional to, the greater costs of providing such benefits to older workers." Schmall, supra note 58, at 838.
\(^7\)492 U.S. 158 (1989).
\(^7\)The portion of the Betts decision which held that a plan is a subterfuge only if adopted after the passage of ADEA and purposefully adopted with intent to discriminate against workers because of age in a non-benefit aspect of the employment relationship, was overturned by the Older Workers Benefit Protection Act. 29 U.S.C. § 621 (1990) Congress [D]isplayed its outrage with the Betts decision by enacting the Older Workers Benefit Protection Act of 1988 . . . [which] was created to eradicate the age discrimination in employee benefits. The OWBPA overturned Betts by eliminating the use of the term "subterfuge." It also specified that the ADEA's prohibition against age discrimination extended to all employee benefits and benefit plans. Bilimoria, supra note 28, at 1078.
\(^7\)434 U.S. 192 (1977).
plan, stratagem, or artifice of evasion.' 79 Thus, under the ADEA, the term subterfuge has consistently been given its dictionary definition by the Supreme Court, which requires plaintiff to prove intent. 80

Whether Betts should govern subterfuge analysis in ADA cases involving disparate insurance benefits is a matter of contention.

F. Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), 81 generally became effective for insurance plan years beginning on or after July 1, 1997. 82 The HIPAA was enacted to assure continuity and portability of health insurance. It applies to employer-provided or individually obtained group health insurance plans 83 and to employer-sponsored self-insured plans covered by ERISA. 84 The Act governs health insurance plans that are made available as a benefit of employment or that are obtained individually. 85 It provides for the continued applicability of state law to the extent state law is consistent with the Act's substantive requirements. 86 Enforcement of the Act is authorized to proceed under state law. 87

In general, the HIPAA prohibits discrimination against individual participants and beneficiaries who wish to enroll in a health insurance plan and/or to renew coverage under a plan when based on health status. The HIPAA places limits on exclusions based on preexisting conditions and

79 Id. at 203.

80 A similar specific intent requirement was later required in an ERISA case, McGann v. H & H Music Co., 946 F.2d 401 (5th Cir. 1991).


82 There are some variations on the effective date of the various parts of the Act. For example: "In general, HIPAA's requirements become effective for plan years beginning on or after July 1, 1997. Thus, group health plans following a calendar year must begin compliance with the PCE and nondiscrimination rules as of January 1, 1998." Gary M. Ford & Mary Ann D. Edgar, Enforcement of the Health Insurance Portability and Accountability Act, ALI-ABA COURSE OF STUDY, Jan. 23, 1997, at 242. "[C]ollectively bargained plans will not be subject to these provisions until the expiration of the agreement as they were in force on the date of enactment of HIPAA." Roberta C. Watson, Employer-Sponsored Health Plans Under Recent Health Insurance Reform Legislation, ALI/ABA COURSE OF STUDY, Feb. 13, 1997, at 850.


prohibits discrimination based on an individual's health status. The Act provides that a group health plan may not establish rules, including continuing eligibility, based on eight specified factors: health status, medical condition (including physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

The purpose of the HIPAA is limited to assuring continued access to insurance. It does not mandate the terms of the available insurance. While the HIPAA forbids discrimination on the basis of physical or mental disability,


The HIPAA was primarily intended to provide a safety net to assure that employees who moved from one employer-sponsored health care plan to another employer-sponsored health care plan would not lose coverage due to restrictions on preexisting conditions, waiting periods, etc. It was recognized that employees were sometimes "captive" to their present employment position because the new position would not cover treatment-in-progress or because the new position had lengthy waiting periods during which the employee and his family were not covered by any health insurance.

But under some circumstances, when an employee leaves one job but does not enter a second that offers health coverage, the safety net envisioned by the HIPAA does not materialize. Under HIPAA, States may allow insurance providers to create high-risk pools for people with serious and expensive health problems. Because the premiums for coverage within such pools are significantly greater in such cases, people are often shut out of the private insurance market. Those who can afford the premiums sometimes are offered only limited annual or lifetime benefits. Nancy Ann Jeffrey, Some States Choose Weak Safety Net Under Portable Health-Insurance Law, WALL ST. J., Aug. 22, 1997, at Cl.

The philosophy behind between two competing views of the proper organization of insurance pools (risk-based or community based) and the consequences of each view are set out in Jacobi, supra note 67. Jacobi's interesting article questions what is meant by insurance: is it intended to be an exercise of mutual aid and social pooling or is it a self-centered calculation of a person's protection of himself against loss?

The HIPAA was enacted shortly after the failure of President Clinton's Health Security Act of 1993, which was designed to ensure that all citizens had health care coverage.

The [HIPAA's] less stirring design aims to discretely modify the competitive marketplace for health insurance... by... thoughtful, if limited, injection of regulation into the world of insurance underwriting... it requires the private insurance market to protect the interests of "poor risks," even when rational actuarial judgment would reject their membership in insurance pools. It reflects a judgment that insurance markets must be structured to enhance the broad availability of coverage. Jacobi, supra note 67, at 366-67.

For a summary of the legislative history of the HIPAA see id. at 367 n.234. It appears that while the portability provisions were generally supported, the largest debate over social pooling concerned the Medical Savings Accounts authorized by the Act.
it does not require particular benefits to be provided nor does it prohibit
limitations on the amount or nature of benefits provided.\textsuperscript{92}

The HIPAA is directed to health insurance. Disability income insurance is
specifically exempted from the requirements of the Act.\textsuperscript{93} Consequently, this
Act offers no relief for those who claim discrimination in the level of benefits
available as a result of disability.

Implementation of HIPAA has been difficult and is being met with
resistance. Resistance came from (1) state legislatures which failed to enact
enabling statutes; (2) concerns that the cost of insuring high risk individuals
would be prohibitive; (3) lack of cooperation among insurers; and (4) carriers
which were using a variety of pricing and marketing tactics to discourage
people from applying for the health coverage HIPAA was supposed to
provide.\textsuperscript{94}

\textbf{G. Mental Health Parity Act}

The Mental Health Parity Act of 1996 (MHPA)\textsuperscript{95} became effective on January
1, 1998 and has a sunset provision date of September 30, 2001. The Act applies
to employer-provided health insurance benefits whether insured or self-insured.\textsuperscript{96} It does not apply to individually acquired health insurance
benefits\textsuperscript{97} and does not preempt state law insofar as state law provides for more
favorable coverage than that provided by the MHPA.\textsuperscript{98}

\textsuperscript{92}The Act
shall not be construed—(A) to require a group health plan, or group health
insurance coverage, to provide particular benefits other than those provided
under the terms of such plan or coverage, or (B) to prevent such a plan or
coverage from establishing limitations or restrictions on the amount, level,
extent, or nature of the benefits or coverage for similarly situated indivi-
duals enrolled in the plan or coverage. 42 U.S.C. § 300gg-1(a)(2).

\textsuperscript{93}42 U.S.C. § 300gg-91(c)(1)(A).

\textsuperscript{94}See, e.g., Clinton Threatens to Punish Health Plans that Violate Insurance Portability
Statute, 67 U.S.L.W. 2027 (July 14, 1998); Federal, State Regulators Tell Congress of Early
Snags in Implementing HIPAA, 66 U.S.L.W. 2201 (October 7, 1997).

\textsuperscript{95}42 U.S.C. § 300gg-5. The legislative history of this act, including the timing and
nature of the compromises that led to its adoption, are recounted in Shannon, \textit{Parity in
Health Insurance, supra } note 30. Shannon concludes that "[a]lthough the bill represents a
hard-fought victory for advocates for persons with mental illness, the final version is
just a start toward insurance equality." \textit{Id.} at 102.

\textsuperscript{96}42 U.S.C. § 300gg-91(b)(2).

\textsuperscript{97}As a result, employers ultimately bear the costs associated with this aspect of health
care reform.

\textsuperscript{98}42 U.S.C. § 300gg-23(a) (1996).
The MHPA does not require mental health benefits to be offered by the plan.\textsuperscript{99} The Act requires only that if mental health benefits are offered by the benefit plan, the plan must not impose annual or lifetime caps on mental benefits that are less than annual or lifetime caps on physical or surgical benefits.\textsuperscript{100}

The MHPA also does not attempt to regulate the terms and conditions under which mental health benefits may be offered. For example, cost sharing or limits on the number of visits or days of coverage are not affected by the MHPA.\textsuperscript{101} It has been noted that the MHPA

will have no impact on such common insurance practices as the requirement of substantially higher deductibles and higher

\textsuperscript{99}(b) Construction: Nothing in this section shall be construed—

(1) as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any mental health benefits;


\textsuperscript{100}The Act provides:

(a) In general

(1) Aggregate lifetime limits

In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental benefits—

(A) No Lifetime limit

If the plan or coverage does not include an aggregate lifetime limit on substantially all medical and surgical benefits, the plan or coverage may not impose any aggregate lifetime limit on mental health benefits.


(2) Annual limits

(A) In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health benefits—

(B) If the plan or coverage does not include an annual limit on substantially all medical and surgical benefits, the plan may not impose any annual on mental health benefits.


The MHPA elaborates what is to be done under circumstances where there are annual or aggregate caps on all or some of the medical or surgical benefits. Generally, in such circumstances, yet-to-be-enacted regulations will direct some kind of averaging.

\textsuperscript{101}(b) Construction: Nothing in this section shall be construed—

(2) in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides mental health benefits, as affecting the terms and conditions (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity) relating to the amount, duration, or scope of mental health benefits under the plan or coverage, except as specifically provided in subsection (a) of this section (in regard to parity in the imposition of aggregate lifetime limits and annual limits for mental health benefits).

co-payments to coverage for mental health benefits than for those provided for other ailments. Employers and health plans can also continue to consider managed care alternatives. Moreover, employers and health plans can now set even higher deductibles or co-payments as a means of controlling the new costs, or they could drop mental health coverage altogether. These entities can also comply with the new requirements, but then establish an aggregate limit for health and mental health benefits that falls below the amount previously authorized just for physical health.\footnote{Shannon, Parity in Health Insurance, supra note 30, at 102-03. It is possible to take a cynical view of the consequences of the Act: it might have the effect that coverage for physical illness will simply be reduced, or that insurers and employers will collude in developing a policy that "complies with the new law, but which 'conveniently' includes a price that is greater than one percent over previous charges. The employer could then decline the coverage. Congress, however, clearly did not intend such collusion." \textit{Id.} at 103.}

Additionally, the MHPA provides exemptions from its requirements for small employers\footnote{The MHPA does not apply in any year in which the provider is a small employer. 42 U.S.C. § 300gg-5(c)(1). A small employer is one who employs more than two but less than fifty employees in any year. 42 U.S.C. § 300gg-91(e)(2).} and for any employer under circumstances where the cost of the plan increases one percent.\footnote{"This section shall not apply... if the application of this section to such a plan... results in an increase in the cost under the plan... of at least 1%" 42 U.S.C. § 300gg-5(c)(2).} The Act does not indicate how this figure should be computed. Thus, the impact of the Act on those with serious mental illnesses is open to debate.\footnote{In the opinion of one author: "Despite the final bill's shortcomings, the Mental Health Parity Act of 1996 represents a huge step forward in overcoming years of discrimination against persons with mental illness. And, even though the bill is substantially narrower than originally conceived, it is 'significant—both symbolically and financially—for those who suffer from mental illness.'" Shannon, \textit{Parity in Health Insurance}, supra note 30, at 103-04.} More to the point, the MHPA excepts disability income insurance from its scope.\footnote{42 U.S.C. § 300gg-91(c)(1)(A) states:
\begin{enumerate}
  \item Excepted benefits. For purposes of this subchapter, the term "excepted benefits" means benefits under one or more (or any combination thereof) of the following:
  \begin{enumerate}
    \item Benefits not subject to requirements
    \begin{enumerate}
      \item Coverage only for accident, or disability income insurance, or any combination thereof.
    \end{enumerate}
  \end{enumerate}
IV. BACKGROUND SOCIAL, ETHICAL, AND LEGAL ISSUES

A. Prevalence of Employer-Provided Health Insurance and Long-Term Disability Insurance

Most Americans who have private health insurance receive it as a benefit of employment.\textsuperscript{107} The nature of benefits received depends in part upon whether the employee works for a government entity or for a large or small private employer. In 1994, state and local governments provided health insurance as a benefit of employment to 87% of full-time employees.\textsuperscript{108} Of that 87%, 99% received inpatient mental health care insurance and 97% received outpatient mental health insurance.\textsuperscript{109} In contrast, only 30% of government employees received long-term disability insurance.\textsuperscript{110}

Of full-time employees in medium and large private businesses, 82% received health insurance as a benefit of employment. Mental health insurance was provided to 80% of those employees.\textsuperscript{111} Long-term disability insurance was received by only 41% of these employees.\textsuperscript{112} Full-time employees in small private businesses are less likely to have any of these forms of insurance: 66% received health care benefits; 20% received long-term disability insurance.\textsuperscript{113}

Employers are the principle source of non-government funded health insurance. Unlike many other western countries, "only the United States relies on a competitive private marketplace and voluntary coverage to provide health insurance to the majority of its citizens."\textsuperscript{114} It has been suggested that one of the reasons health insurance remains a private, profit-driven benefit, rather than an individual right assured by government, lies in the lingering spirit of

\textsuperscript{107}Employer-sponsored health insurance protects not only the person employed, but his dependents as well. "In 1991, just over half of all workers (55 percent) were covered directly by their own employer; all other employer-insured workers were covered only by another worker's plan. Nationally, for every ten workers insured by their own employer, another three were covered only as dependents." Deborah Chollet, \textit{Employer-Based Health Insurance in a Changing Work Force}, 1994 \textit{HEALTH AFF.} 315, 316.


\textsuperscript{109}Id. Obviously, the statistic does not reflect the extent of the benefits. Just by contrast, it is interesting to note that 88% of all employees received parking benefits.

\textsuperscript{110}Id.


\textsuperscript{112}Id.

\textsuperscript{113}Id.

\textsuperscript{114}Jacobi, \textit{supra} note 67, at 315. "[M]ost non-elderly Americans obtain health insurance from non-governmental sources, and a substantial percentage have no health insurance at all." Id.
rugged individualism that has informed so much of American law and character.115

Although most non-elderly people who have health and disability insurance receive it as a benefit of employment, there is no requirement that employers provide such insurance. Some believe that to require employers to provide health insurance would have unacceptable consequences such as high cost, disproportionate financial burdens on small firms, and a possibly negative impact on the labor market.116 Consequently, though some proposed legislation and commentators have explored the idea,117 there has been little support for a legislative requirement that employers must provide health insurance. On the other hand, the inadequacy of employer-sponsored insurance to provide for disabled, mentally ill, or high-risk employees is well-recognized and was an element in the debate over national health insurance.118 Legislation that requires certain terms to be included in health insurance contracts as regulations of the insurance industry (rather than regulations of employers) has been more common, both on the state and on the federal level. Some states require insurers to provide certain terms.119 A few states require minimum mental health coverage.120 But to the large extent that employer-provided insurance falls within the scope of ERISA, such state legislation is an ineffective means to assure minimum contract terms insofar as it appears to be common for employers to self-insure for the purpose of avoiding state insurance mandates.121

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115"Health insurance in America is an odd thing. We are imbued with rugged individualism and a preference for voluntary action. In health insurance, this manifests in the peculiar American interest in individual responsibility, an interest that coexists uncomfortably with the underlying goal in insurance law to pool risk." Id. at 314.

116Richard G. Frank & Thomas G. McGuire, Mandating Employer Coverage of Mental Health Care, 1990 HEALTH AFF. 31, 32. On the other hand, "[r]equiring employers to insure workers is . . . attractive to legislatures because it requires few or no direct public expenditures. Costs of insurance for the working poor or near-poor are kept 'off budget,' requiring no new taxes." Id.

Another result of mandating employers to provide employees with health insurance that might be attractive to legislatures would be the shifting of treatment costs from the state to the private sector. Maria O'Brien Hylton, Insurance Risk Classification After McGann: Managing Risk Efficiently in the Shadow of the ADA, 47 BAYLOR L. REV. 59, 76 (1995).

117Frank & McGuire, supra note 116, at 32.

118Hylton, supra note 116.

119See, e.g., id. "All fifty states, to one extent or another, now regulate the terms of group health insurance contracts. Some states demand maternity coverage. Others require benefits for mental health problems, prosthetic devices, and alcohol and drug treatment." Id. at 75 (omitted footnotes that collect citations to state statutes).

120See, e.g., id. at n.56 (collecting state citations).

121See, e.g., id. at 77-88; Schmall, supra note 58, at 820-21.
Recent federal legislation addresses the problem of inadequate insurance in a piecemeal way. It is clear that, however gradually, federal legislation may be accomplishing a modest degree of health care reform.

Notwithstanding recent legislation, the importance of the fact that most Americans who have private, non-government provided health insurance obtain it as a benefit of employment must not be overlooked. Both employers and insurers are bound by the values and ethics of commerce which are in dramatic contrast to the values and ethics of medicine or health care. Employers who select the terms of health and disability insurance for their employees are setting national policy for the quality and scope of health care.

B. Nature of Long-Term Disability Insurance

Both health insurance and long-term disability insurance tend to provide inferior coverage for mental conditions compared with physical conditions. Health insurance contracts may place annual or lifetime limits on mental health care. Disability contracts may provide benefits for only about two years for mental disabilities but benefits until age 65 for physical disabilities.

Health insurance and disability insurance serve different functions. Health insurance is intended to cover expenses incurred as a result of illness or accident. Disability insurance is intended to cover income for a specific period of time after illness.

122Recent federal legislation intended to provide essential insurance coverage includes the Family Medical Leave Act, the Health Insurance Portability and Accountability Act of 1996, the Newborns' and Mothers' Health Protection Act of 1996, and the Mental Health Parity Act of 1996.

123For example, it has been reported that President Clinton will endorse a "Consumer Bill of Rights and Responsibilities" designed to improve the quality of health care. Matters such as coverage caps and inequality of treatment between physical and mental illness may be addressed. Clinton Is Poised to Endorse Prescription by Panel on How to Improve Health Care, WALL ST. J., Oct. 21, 1997 at B5.

124Jacobi, supra note 67, at 314.


126See infra Parts V-VII.
dental injury. While there are many types of contracts, most commonly health insurance pays for expenses such as physician fees and surgical costs, medical testing, prosthetic devices, therapeutic treatment, medications, and costs of hospitalization. It has been pointed out that health insurance policies are "policies of indemnity ... [which] try only to place the insured in a position similar to that which he had before the loss." Only actual expenses will be paid. An insured who incurs no expenses receives no benefits.

Disability insurance was first developed in association with life insurance. At that time, disability insurance was intended to assure that the premiums on the life insurance policy would be paid. It was not intended to protect against loss of wages in employment. The remnants of this history remain. When disability insurance is provided as a benefit of employment, it protects an insured employee from suffering an "economic death."

Generally, disability insurance is intended to protect the income of an insured who has suffered a disabling illness or accident and can no longer work. In that way, disability insurance has the same goal as unemployment insurance. However, "[w]hile unemployment insurance protects against loss of income/employment due to a wide variety of causes, disability protects only against such losses that are attributable to poor health." Lee Russ & Thomas F. Segalla, Unemployment and Disability Ins., in COUCH ON INS., § 165, Folio Infobase (CD ROM 12-96).

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127 Darwin B. Close, Life Insurance Including Health and Disability Insurance § 10.2, at 157 (2d ed. 1987). Generally health insurance will cover losses incurred from accidental death, and life insurance will cover losses incurred by natural death. Id.


129 Indeed, often only a portion of expenses will be paid, for several reasons. The now-familiar concept of cost-containment is one; the problem of moral hazard is another.


131 Holmes's Appleman on Insurance, 2d § 1.27, at 139 (1996).

132 The term disability is a term of art and includes many subcategories such as total disability, and temporary, permanent, and partial disability. These terms are not of particular consequence to this discussion, which presumes total disability.

133 In that way, disability insurance has the same goal as unemployment insurance. However, "[w]hile unemployment insurance protects against loss of income/employment due to a wide variety of causes, disability protects only against such losses that are attributable to poor health." Lee Russ & Thomas F. Segalla, Unemployment and Disability Ins., in COUCH ON INS., § 165, Folio Infobase (CD ROM 12-96).


135 Close, supra note 127, § 1.3, at 168-69. It can also be called Accident and Sickness, Accident and Health or Disability Income Insurance.
generally pays the insured a proportion of the insured’s net income. Rather than easing the burden of excess medically related expenses, "[p]olicies providing total and permanent disability benefits are designed to provide a substitute for earnings when the insured is deprived of capacity to earn by bodily disease or injury." Disability insurance is not tied to the incurring of additional expenses as a result of illness. Rather, it is tied to interruption of wages from employment. "[T]otal disability in an occupation is to be measured by the absence of an individual earning capacity rather than the absence of income." To assure continuation of income most disability payments pay over a period of years rather than in a lump sum, usually until age 65, when Social Security benefits generally become available.

There are two types of disability policies: occupational disability policies and general disability policies. Occupational disability policies protect the insured against inability to continue in the occupation in which he was employed at the time the policy was issued. General disability policies protect the insured against inability to continue in any occupation. Notably, "[t]otal disability does not mean total absolute helplessness but rather ... [an] infirmity or disability [that] renders the person unable to perform substantially all the material acts of an occupation which his age, training, experience and physical condition would suit him for ..." For this reason, disability insurance may

136Typically, an insured receives between sixty-six and eighty percent of his take home pay. To pay one hundred percent would overcompensate the insured because he is no longer incurring the expenses of participating in the workforce (work clothes, transportation costs, etc.) and is thought to increase the moral hazard. See id. § 11.8, at 214.

13715 ANDERSON & RHODES, supra note 130, § 53:40, at 75.

138Again, the details of this point are numerous. A person may be totally disabled even if he continues to work due to a heroic constitution or out of economic necessity. Taking a less demanding employment or a part-time position does not necessarily disqualify one for disability benefits. Id. "[T]he term 'total disability' as used in general disability clauses is a relative one depending in a large measure upon the character of the occupation or employment and the capabilities of the insured ..." Id. § 53:51 at 88.


140HOLMES, supra note 131, § 1.27, at 139 (1996).

141Id. at 140.

142Id. at 142. Often occupational disability policies will have a fixed term, after which the insured must demonstrate general disability. Id. Some courts do not recognize these differences and will construe even a general disability policy to be an occupational disability policy. Id. at 143.

14315 ANDERSON & RHODES, supra note 130, § 53:40 at 76. It is a reasonable person test: The test of total disability is satisfied when the circumstances are such that a reasonable man would recognize that he should not engage in a certain activity even though he literally is not physically unable to do so. In other words, total disability does not mean absolute physical inability to transact any kind of business pertaining to one’s occupation,
pay an insured even if the insured has substantial investment income or is fabulously well-off and incurs no decrease in his standard of living as a result of his disability. A disability may be deemed permanent, and benefits paid, even if there is a possibility that the condition may be cured or improved. "[T]he fact of recovery, under this view, does not destroy the 'permanent' character of the disability..." Instead, "it is sufficient under such clauses that total disability shall have been uninterrupted for the period of time stipulated in the policy..." and that it appears it will continue for an indeterminate time. Courts will take into account a variety of factors such as the insured's occupation, age, education, and skills in order to determine whether he is disabled. This type of insurance may present the problem of adverse selection as well as a moral hazard for dissembling a serious injury.

Both health insurance and disability insurance can be obtained through group insurance. Employers often obtain group insurance for their employees. Generally, termination of employment will terminate the insurance coverage. The phrase termination of employment can be ambiguous. For example, "[I]leaving employment after an injury does not destroy the

but rather that there is a total disability if the insured's injuries are such that common care and prudence require him to desist from his business or occupation in order to effectuate a cure..."

Id. at § 53:118, at 165.

Obviously, the terms of the insurance contract control. Some provide benefits only if the insured is unable to engage in any gainful occupation, in which case the insured "must be disabled from doing and performing the substantial features of any gainful occupation within the range of his mental and educational capacity, with the skill and accuracy usual to any such occupation." Id. at § 53:52, at 90. Some states have statutes which regulate or prohibit the terms of disability contracts.

144 Id. at § 53:116, at 163.

146 Id. at 164. "[B]ut if recovery is reasonably certain after a fairly definite time, the disability is not permanent." Id.

147 CLOSE, supra note 127, § 11.8, at 157.

149 While it is clear that "[e]mployment ceases and group insurance is terminated when the department in which the insured worker is discontinued, his name stricken from the payroll, notice thereof given to the insurer, and the policy canceled," 19 ANDERSON & RHODES, supra note 130, § 82:101, at 848, other events do not have such clear consequences.

The related policy terms cease to be employed, while in the employ, and cease to work, are also ambiguous. Id. at § 82:97, at 843-46.
employee’s rights under a group policy."150 and group insurance "[c]overage is not necessarily terminated by an inability to perform the task for which the employee was hired."151 Temporary layoffs may or may not terminate the insurance, depending upon the terms of the policy. Retirement is ordinarily regarded as a termination of employment and of coverage.152 On the other hand, "[w]here termination of coverage under a group policy rests on cessation of the status of employee, coverage does not terminate where the cessation is due to permanent and total disability rendering a return to work impossible, so long as the cessation of work was not voluntary."153 It is clear that "[t]ermination of employment after rights have vested under a group policy has no effect upon the insurer’s liability."154

C. Prevalence of Mental Illness and Impact of Health and Disability Insurance

Restrictions on Treatment

Statistics on the prevalence of mental illness have been variously reported. One commentator found that 15% of the American population has mental or substance abuse disorders.155 Another determined that:

At any given time, one percent of the population of the United States is being treated for severe mental illness. Schizophrenia affects from one-half to one percent of the population of the United States during any six-month period, and has a lifetime prevalence of nearly two percent. The lifetime prevalence of mood disorders, such as bipolar affective disorder, is around nine percent . . . . Over ten million Americans will suffer some form of significant depression disorder at least once in their lives. Although the majority of even the most severe

150Id. § 82:100, at 848.
151Id. § 82:104, at 851.
152Id. § 82:112, at 857.
15319 ANDERSON & RHODES, supra note 130, § 82:115, at 859.
154Id. § 82:116, at 859.

So, a provision in a group policy which automatically cancels total disability insurance on termination of employment precludes recovery of benefits for total disability occurring after the termination of employment, although the injury resulting in total disablement was sustained before, but it does not preclude full recovery of benefits where the termination of employment is after total disability has occurred.


155Edwards, supra note 29, at 392. This figure would seem to make the prospect of providing insurance against mental illness prohibitively expensive and justify inferior mental health coverage. However, the figure includes minor or temporary emotional problems along with serious mental illnesses and organic brain diseases. It is the latter which cause long-term disability and is the focus of this article. As the text indicates, the incidence of serious mental illnesses is much lower than that of lesser problems.
mental illnesses can be treated with some degree of success, as few as one fifth of those with mental disorders actually receive care.\textsuperscript{156}

Whether medical care is received for mental illness depends to a large degree on whether the person affected is covered by health insurance. In 1993, 16.8\% of non-elderly Americans had no health insurance. The number of Americans who were without health care for at least one month during a 28 month period between 1992 and 1994 was 27\%, or 66 million people.\textsuperscript{157} Among those who were without health care, the mentally ill were "disproportionately represented."\textsuperscript{158} One figure places the number of uninsured mentally ill persons at 300,000.\textsuperscript{159}

Whether a person under sixty-five has health insurance is largely dependant upon he whether he is employed.\textsuperscript{160} While a person with a serious mental illness often cannot work, even those who can work often find that health insurance is not provided as a benefit of employment.\textsuperscript{161} A person who is employed and receives health benefits usually finds that health coverage for mental illness has many more restrictions and limitations than those for physical illness.\textsuperscript{162} Typically, health insurance policies cover shorter durations of hospitalization, impose lower caps on covered expenses, pay for fewer outpatient visits per year, require larger copayments, and impose low annual or lifetime maximum coverage.\textsuperscript{163} It has been determined that 90\% of employer-provided health care plans impose severe limits on mental health plans.\textsuperscript{164}

Policies that allow 365 days in-patient care for physical illness allow only 45 days for in-patient psychiatric care. Policies that provide a lifetime cap of $1 million for physical care have a $50,000 cap for mental


\textsuperscript{157}Jacobi, supra note 67, at 315 n.16 (people over 65 are generally covered by Medicare).

\textsuperscript{158}Ramage, supra note 156, at 956.

\textsuperscript{159}Id. (citing Agnes Rupp, Underinsurance for Severe Mental Illness, 17 SCHIZOPHRENIA BULL. 402 n.10 (1991)).

\textsuperscript{160}Jacobi, supra note 67, at 315 n.16. (A large percentage of non-elderly persons who have insurance receive it as a benefit of employment. "In 1993 61.1\% of non-elderly Americans were covered by employment-based health insurance." Id.

\textsuperscript{161}Ramage, supra note 156, at 957. ("Employment . . . does not guarantee health insurance coverage since approximately three quarters of the uninsured are employed or are the dependents of employed persons.")


\textsuperscript{163}Ramage, supra note 156, at 957.

\textsuperscript{164}Shannon, Parity in Health Insurance, supra note 30, at 68.
illness. Policies providing unlimited outpatient visits for physical care allow only 20 outpatient visits for mental illnesses.\textsuperscript{165}

Several interrelated explanations have been given for the disparate coverage of mental illness and physical illness in employer-provided health insurance contracts. There is a perception that successful treatment of mental illness is difficult to measure. Also, it is thought that inferior insurance coverage for mental illnesses is one area in which cost containment is needed because of the problems of adverse selection and moral hazard, and the perception of the vagueness of success of treatment of mental illnesses.

The problem of adverse selection is that those with "superior knowledge of their own circumstances switch in and out of plans in anticipation of particular needs,"\textsuperscript{166} leading to a distorted risk pool.\textsuperscript{167} Those who know in advance of their need for such coverage may disproportionately enroll in a plan that provides better mental care coverage. The result is an increase in costs beyond levels that would normally be predicted.\textsuperscript{168} One consequence of this might be that only those who do not need the coverage can afford it.

Studies have shown that demand for mental health services increases with the availability of insurance and decreases with increased cost-sharing.\textsuperscript{169}

\textsuperscript{165}Id. quoting 142 CONG. REC. 53591 (daily ed. Apr. 18, 1996) (statement of Sen. Domenici).


\textsuperscript{167}Adverse selection is an important problem from the perspective of social risk spreading and increased access to coverage for three reasons. First, the tendency of those who perceive themselves to be low-risk to refuse to buy coverage is counter to the goal of full coverage. Second it is argued that adverse selection can destabilize an insurance market, leading to a "death spiral" of premiums. Third, depending on the validity of the first two concerns, adverse selection may suggest that the purchase of health insurance should be mandated—a politically problematic conclusion.

\textsuperscript{168}Private firms may underprovide coverage for conditions like mental illness. One reason for insufficient coverage arises from insurers' fear of adverse selection. The insurers are concerned that any plan offering better protection against mental health care costs may attract a disproportionate number of persons who anticipate using mental health care. Adverse selection will increase costs beyond the initially predicted levels and make it difficult to price the policy.

\textsuperscript{169}Richard G. Frank & Thomas G. McGuire, A Review of Studies of the Impact of Insurance on the Demand and Utilization of Specialty Mental Health Services, HEALTH SERV. RES. 21:2, 241 at 245 (June 1986, Part II); Carl A. Taube, The Economics of Mental Health Services through 1986: Empirical Studies, Administration and Pol'y in MENTAL HEALTH 16:3, 115 (Spring, 1989) (collecting studies conducted to determine whether persons with mental illnesses could predict their future needs for care.)
Whether this means that the availability of insurance encourages treatment of minor conditions or whether it means that the availability of insurance allows people who are in genuine need of treatment to obtain it is not clearly understood. On the other hand, what should be understood is that treatment required by a person with a serious mental illness or organic brain disease cannot be viewed as optional. Treatment in such a case can mean the difference between a productive life and death. Adverse selection and resulting uncontrollable costs is perhaps a more serious concern when the insured can foresee a need for short-term care for minor emotional problems. It is difficult to conceptualize the problem of adverse selection for one stricken by a neurobiological disorder. Unfortunately, both types of care are classified as mental illness subject to limited insurance coverage.

The moral hazard problem occurs where insured individuals overuse medical services or have no incentive to recover from illness when coverage is too broadly available. The moral hazard concern is particularly powerful in regard to treatment for mental illness. "Potential insurers of mental health care are especially concerned with moral hazard because . . . many of the symptoms of mental illness are part of a continuum with everyday forms of distress; . . . [and] some forms of treatment—especially psychotherapy—seem similar to non-professional forms of human support and interaction."

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170 Frank & McGuire, supra note 169, at 245. Part of the problem in understanding the consequences of insurance is the degree to which the mental health care provider may influence the patient's increased use of insured services. It is known that the providers influence demand in the general health area, but some studies have concluded that in all cases such influence is limited. Id. at 243-44.

171 Anne Marie O'Keefe, Reforming Insurance Law to Provide Equitable Coverage for Persons with Neurobiological Disorders, NEW DIRECTIONS FOR MENTAL HEALTH SERV., No. 54, 101 at 102 (Summer 1992) [hereinafter, O'Keefe, Reforming Insurance Law].

172 It has been suggested that it is easier to treat people with transitory adjustment problems than tackle the long-term problems of persons with chronic brain disease. The increase in providers and consumers of psychotherapy and the popular desire to have such services covered by insurance policies have led to a trade-off made at the expense of people with serious chronic neurobiological brain diseases.

173 [Insurers] fear that insureds will begin to act more like consumers of such services if their "consumption" will be reimbursed by a third party. Insurance companies would like to avoid this result. To that end, insurance policies cover very small percentages of out-patient mental services. This, in turn, acts as a disincentive to long-term, regular psychiatric visits or therapy.


174 James E. Sabin & Norman Daniels, Determining "Medical Necessity" in MENTAL HEALTH PRACTICE, 1994 HASTINGS CENTER REPORT, 5 at 9-10. The authors continue: Public support for mental health insurance coverage, historically tenuous at best, might be compromised further if the public believed that third-party resources were subject to even more moral hazard than
However, the term mental health care encompasses a broad range of disorders, some of which are far more serious and threatening to the individual than others. To "assume that all types of mental health services for all types of patients with all types of mental disorders are subject to moral hazard to the same degree... is contrary to clinical experience and common sense." 177

There is a perception that successful treatment for mental illness is less science than persuasion. A person who has a broken arm has a cast applied and the bone mends, largely without conscious effort. But a person with a mental illness must participate in the treatment. Insofar as it is believed that a person is responsible for contracting his own mental illness, he is perceived to be responsible for willing his own recovery from it.

Physical illness has objective symptoms and signs that indicate its presence. When these are lessened, the patient improves. This model implies that the illness, as an ontological entity, exists in an objective sense.

Many mental disorders follow this model of physical illness, at least to a degree, for example, schizophrenia and some depressions. However, some disorders do not fit this model. Symptoms can be vague, they shift frequently and they involve an element of volition . . . .

In physical illness subjective symptoms are expected to respond to objective treatments without an observer effect. In mental illness the effect of observation on the degree of symptoms reported can be significant. 176

As a result of this perceived uncertainty in treatment, it is believed to be difficult to predict the cost of treatment for mental illness where the duration of treatment is seen to be indefinite and where treatment is dependent upon the effort of the insured to recover. 177


176Douglas P. Olsen, Ethical Cautions in the Use of Outcomes for Resource Allocation in the Managed Care Environment of Mental Health, 9 ARCHIVES OF PSYCHIATRIC NURSING No. 4 at 173, 174 (1995). One consequence of the widely-held belief that treatment of mental disorders is subjective and imprecise is the reluctance of insurers to support parity of mental health services with other medical services. The "fear [is] that if mental health services were given parity with other medical services, . . . insurance funds will be siphoned into a 'bottomless pit.'" Sabin & Daniels, supra note 174, at 5.

177"Despite evidence of improvements in treatment effectiveness, many people believe serious mental illness is incurable and a drain on society's resources." Steven S.
That many mental illnesses are highly treatable is overlooked. For example, 80-90% of treatment for depression is successful.\(^1\) In fact, treatment of some mental illnesses has a higher success rate than treatment of physical illnesses. For example, while treatment of manic depression is successful 80% of the time, and treatment of schizophrenia is successful 60% of the time, "commonly reimbursed procedures such as angioplasty and arthrectomy have only a 41-percent and a 52-percent ratio."\(^2\) One study revealed that alcohol and substance abuse—behavioral disorders, not mental diseases—were the primary areas of escalating mental health care costs, while the costs for "inpatient psychiatric services for adults (with serious mental illnesses) grew less rapidly than did overall health care costs."\(^3\)

The reasons for disparity in coverage for mental illness arise from several sources. First, the lingering social stigma against mental illness thrives on the idea that one whose character weakness has led to mental illness should take responsibility to improve his character to achieve a cure.\(^4\)

Many members of the public and the insurance industry still view individuals with mental illness as causing their own mental problems. Consequently, this segment of the public believes that persons with mental illness should be able to overcome their illness simply by their own efforts. . . . In addition, remnants of outdated propositions that mental illnesses such as schizophrenia are mythical and do not exist still haunt current mental health law and policy.\(^5\)

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\(^2\) Olsen, *supra* note 176, at 174. It should be noted, however, that "as many as two-thirds of people with depression do not seek proper treatment." *Id.* at 175.


\(^4\) Shannon, *The Brain Gets Sick Too*, supra note 162 at 373 n.29 quoting ANNE MARIE O'KEEFE, NATIONAL ALLIANCE FOR THE MENTALLY ILL, ADVOCATING FOR INSURANCE REFORM 14-15 (1991). ("Many members of the public and the insurance industry still view individuals with mental illness as causing their own mental problems. Consequently, this segment of the public believes that persons with mental illness should be able to overcome their illness simply by their own efforts." *Id.* at 371.) See also Cook, *supra* note 173, at 345. One commentator's criticisms of proposed EEOC regulations implementing the ADA includes pervasive bias and stigma against mental illnesses. See Mary T. Giliberti, *The Application of the ADA to Distinctions Based on Mental Disability in Employer-Provided Health and Long-Term Disability Insurance Plans*, 18 Mental & Phys. Disab. L. Rep. 600 (1994).*}

\(^5\) Shannon, *The Brain Gets Sick Too, supra* note 162 at 372.

\(^6\) *Id.* at 371. Shannon continues,

[A]titudes that the patients somehow caused their own problems or should just will themselves to get better are as ludicrous as suggesting that sufferers of brain tumors, lung cancer, diabetes, or Parkinson's disease could be cured if they simply tried hard enough or wanted
Similar expectations and restrictions on treatment would not be tolerated for physical illnesses. One commentator noted that "[t]he EEOC recognized that limitations in coverage for impairments such as AIDS, cancers, and blood disorders are disability-based distinctions that insurers must justify to avoid violating the ADA. At the same time [the EEOC] allows insurers to limit coverage for mental conditions without providing any justification or actuarial evidence." It is clear that insurance for mental illness is "mired in continuing stigma, expectations that the public sector should care for the mentally ill, and irrational beliefs about the nature of mental illness..." A second reason for the disparity in coverage for mental illness is that, although it is now widely understood that serious mental disorders such as schizophrenia or bipolar disorder are biologically caused, they are grouped by insurers with so-called "adjustment disorders." They are both subjected to highly restricted coverage, even though "behavioral disorders, . . . not neurobiological brain diseases, have accounted for the largest portion of the escalating costs." The ironic consequence is that those with the most serious

to be well. Ignorant stigmatization, however, should not serve as a barrier to appropriate insurance coverage for medical illness, even if that illness affects the patient's brain.

Id. at 372.

Giliberti, supra note 180.

Sharfstein, supra note 177, at 453. See Ramage, supra note 156. ("A recent survey reported that forty-three percent of Americans still view depression as a personal weakness rather than a true health problem." Id. at 973).

Shannon, The Brain Gets Sick Too, supra note 162. ("In the past several years, medical researchers have made numerous findings establishing that serious mental illnesses such as schizophrenia, bipolar affective disorder, and depressive illness are biologically-based diseases of the brain." Id. at 367).

Insurance companies have tended to use vague clauses to provide benefits for "mental health coverage" or for "mental/nervous disorders" without further definition of what was intended to be covered by the language. By using terms that employ broad rubrics such as "mental health" or "mental/nervous disorders," insurers have tended to include biologically based serious mental illnesses in the exact same category as all other mental, emotional, and behavioral problems. Accordingly, the exact same policy limits and exclusions apply across the board, regardless of the nature of the "mental" problem or illness involved.

Shannon, Parity in Health Insurance, supra note 30, at 68.

See also, Shannon, The Brain Gets Sick Too, supra note 162. ("Despite the overwhelming medical findings that serious mental illnesses are in fact organic diseases of the brain, health insurance policies tend to treat these illnesses differently from other physical ailments." Id. at 370).

Shannon, Parity in Health Insurance, supra note 30, at 70.
illnesses, which may be highly treatable,\textsuperscript{188} can be excluded from treatment because of being classified by insurers with less serious, less predictably treatable behavioral disorders.\textsuperscript{189} This result has been justly criticized:

\begin{quote}
[T]hrough the use of overbroad terms setting policy limits or exclusions . . . insurance companies are covering serious mental illnesses in the same manner as the purely emotional or coping problems of the "worried well." This results in unfair, discriminatory insurance treatment against persons whose mental illnesses are, in fact, organically- or biologically-based brain diseases.\textsuperscript{190}
\end{quote}

\textsuperscript{188}In the debates on the recent health care reform bill, Senator Domenici pointed out statistics revealing that treatment success rates for serious mental illnesses are often better than for commonly reimbursed treatments for other physical ailments, yet the insurance limitations commonly apply only to the mental illnesses. See [142 Cong. Rec. S3591 (daily ed. Apr. 18, 1996) (statement of Sen. Domenici).] (observing that "[t]reatment for schizophrenia has a 60 percent success rate; manic depression, 80 percent; major depression, 65 percent. Yet commonly reimbursed procedures such as angioplasty and arthrectomy have only a 41-percent and a 52-percent ratio. . . .").

\textsuperscript{189}Although serious mental illnesses such as schizophrenia, bipolar affective disorder, and depressive illness are not curable, they are treatable diseases. . . . Treatment for serious mental illnesses includes a number of medications that can alleviate or reduce the symptoms of the diseases. For example, lithium has proven very helpful to a number of persons suffering from bipolar affective disorder. Similarly, psychiatrists have found that a number of antipsychotic medications can help alleviate the biochemical imbalances present in persons suffering from schizophrenia.

\textsuperscript{190}Id. at 374. The result is difficult to justify on either a policy or an economic basis. A study by the accounting firm of Coopers & Lybrand opined that a full [mental health] parity measure could reduce public sector spending on mental health "by $16.6 billion or about 33% of current public expenditures for mental illnesses" and that the privatizing of
A third reason for disparate coverage relates to the difficulty of predicting when mental illness will strike an individual: "It is not feasible to predict mental illness with enough accuracy to classify the risk of contracting those mental illnesses. Therefore, insurers create across-the-board limitations to avoid the expenses incurred by those few who are at high risk for mental illness."191

Insofar as risk classification is possible, high and low-risk individuals may be placed in different pools or charged different premiums. These practices raise issues about the purposes of insurance. "Health insurance is premised, in part, on notions of mutual aid and social pooling—the common effort to ameliorate each person's risk of catastrophic medical expense. But in the United States it has also come to mean 'a person's self-centered calculations to protect himself against loss.'"192 Such argument could be (improperly) based on the claim that sick people "deserve" or "earn" less.193 The idea that insurance pools should be created to reflect the relative risks of the members, rather than combining all members in a community pool, has been harshly criticized.194

When mental health insurance coverage is limited or too expensive, whether one is able to secure medical care depends either upon personal or family resources or upon one can gain access to funding from welfare programs.195

mental health would create efficiencies that could "lower national expenditures on mental health by $5.5 billion dollars [sic] or about 7.6% of total mental health costs."

Shannon, Parity in Health Insurance, supra note 30, at 71 n.27 (citing Coopers & Lybrand, An Actuarial Analysis of the Domenici-Wellstone Amendment to S.1028 "Health Insurance Reform Act" to Provide Parity for Mental Health Benefits Under Group and Individual Insurance Plans 1 (Draft, Apr. 8, 1996) (emphasis omitted)(on file with Shannon)).

191Cook, supra note 173, at 360.

192Jacobi, supra note 67, at 312 (citing William A. Glaser, HEALTH INSURANCE IN PRACTICE: INTERNATIONAL VARIATIONS IN FINANCING, BENEFITS, AND PROBLEMS 14 (1991)).

193See Schmall, supra note 58, at 785.

194[H]owever . . . [t]he answer, not to put too fine a point on it, is that is what insurance is for. High risk people are lumped together in an insurance group with a vastly greater number of low-risk people . . . All insurance, is virtually by definition, a system of cross-subsidies: The lucky people who don't get sick subsidize, with their premium payments, the unlucky ones who do get sick. The lucky ones tend not to resent this arrangement very much because they'd rather be healthy than sick, and because they understand that someday they too might get sick, in which case the insurance subsidy would run in their favor.


195"Only patients with acute illnesses susceptible to short-term care or ample private resources are treated in the private sector. The remainder, including most of the chronically ill, are relegated to often-overburdened public-sector facilities." Paul S. Appelbaum, Litigating Insurance Coverage for Mental Disorders, 40 HOSP. AND COMMUNITY
Personal or family resources are often insufficient to pay for needed care. One commentator has summarized the situation in this way:

Unless they are personally wealthy, individuals seeking mental health care quickly run out of viable alternatives. If insured, they quickly expend their mental health care benefits. If uninsured, the high cost of mental health care quickly consumes their private resources. If destitute, they face the shortage and delay of public facilities. Many people needing treatment thus must go without.

The impact of mental illness on the family is more than economic. Studies indicate that mental illness of an adult family member can jeopardize the physical health of other family members. In one study, "25 percent of families reported a physical illness due to problems associated with living with a mentally ill person."

Where insurance is not available, the issue becomes one of access to health care. The question of access to health care has ethical implications that are

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196 "The family, the basic building block of American society, also is affected by mental health problems. Families of the mentally ill often bear the initial burden of care, and soon collapse under it. Mental illness has more than one victim." Ramage, supra note 156, at 975. "[S]erious mental illness is one disease that can easily drive [a family] into bankruptcy.... Simply because a [neurological brain disease] attacks the brain instead of the liver or heart, families face financial ruin when a child or other family member develops [the disease]." O'Keefe, Reforming Insurance Law, supra note 171, at 101-02. See also, Rubin, supra note 168, at 144.

197 Ramage, supra note 156, at 958.

On the subject of exhaustion of personal resources in the course of payment of medical bills, an interesting article by Doyle and Mahfood shows that where an insurance plan contract agrees, for instance, to pay eighty percent of allowable medical expenses, the insurer actually pays less because of an undisclosed discount arrangement with the service provider. As a result, the insured actually pays more than his agreed percentage of the cost of treatment, and so exhausts personal resources sooner than should have been necessary. Ellen M. Doyle & George G. Mahfood, The 80/20 Percent Solution: Enforcing Medical Coverage Promises, TRIAL, October 1996 at 32.


199 Issues involving access to health care often seem to raise the specter of rationing. It has been argued that health insurance cost control and coverage limits cannot be thought of as true rationing of health care, inasmuch as the care is still available if the patient, rather than the insurer, is willing to pay for it (at least theoretically.) "As long as the patient remains free to purchase noncovered care out of pocket, the charge that care itself is being rationed should not finally stick...." Havighurst, supra note 166, at 1761-62.

On the other hand, it has been noted that "patients with 'substandard' third-party reimbursement rates have difficulty commanding the attention, much less the loyalty, of many physicians." Capron, supra note 125, at 747.
especially complex where health insurance purchased privately, or received as a benefit of employment, is involved.\textsuperscript{200} The complexity arises because of the way in which intimate life and death issues are juxtaposed with a private industry that exists primarily to generate a profit.\textsuperscript{201}

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It is not unusual to find that denial of insurance coverage results in a denial of care, not only in the mental health area, but also for physical illnesses. See, e.g., Richard A. Hinden & Douglas L. Elden, \textit{Liability Issues for Managed Care Entities}, 14 \textit{SEToN HALL LEGIS. J.} 1, 54 et seq. (1990). The often-made argument that the insurer is merely declining to pay for a particular treatment and not keeping the insured from obtaining the treatment at his own cost is disingenuous because insurers are trying to affect patterns of health care usage by enforcing cost-containment policies against individuals.


\textsuperscript{200}In an article addressing the ethical foundations of health care reform, the authors recognized that:

The more uncertain or compromised the choices among values, the more likely the [health care] scheme will exhibit high levels of institutional complexity. For complex institutional arrangements often are devices for managing conflict and uncertainty. In this sense, a health care plan can be viewed as a design for the conduct of further struggles over both the "right" and the "good." A system that has resolved more of these struggles in a relatively straightforward way can have a simpler institutional design. More importantly, \ldots no ethically acceptable system is likely to have wholly coherent ethical commitments. Hence, institutional complexity is a necessary price for ethical acceptability.

Graetz & Mashaw, \textit{supra} note 9, at 93.

\textsuperscript{201}Commentators are no more satisfied with the ethical quality of the actions taken by those who develop social policy with regard to disabled persons. Drimmer argues that virtually all social progress of disabled persons is linked to their individual ability to work as productive members of the workforce:

During the twentieth century, Congress enacted several laws which focused on people with disabilities. Most of these laws authorized services to help "cure" what are considered "ailments" within individuals who have disabilities in order to increase national production and decrease welfare spending. The few recent laws seeking to provide rights and remedies to people with disabilities have consistently failed to recognize them as complete citizens, acknowledging them only as "flawed" individuals not at fault for shortcomings that society must endure. The Americans with Disabilities Act of 1990 \ldots considered a comprehensive bill of rights for people with disabilities, merely continues this begrudging treatment. In pursuing this course, Congress has issued a message that people with disabilities do not deserve full citizenship or equal participation in the community and
Currently, Americans' health care access disparities take many forms. Inadequate health care and the imposition of excessive burdens to obtain health care are included as problems resulting from a lack of insurance and resources. The issue becomes: to what extent are these ethical problems? This issue has been addressed by recognizing that in American society many goods and services are distributed unevenly without concern that an injustice is being done. Yet health care is regarded differently, and its distribution is governed by principles of fairness that dictate equitable access to an adequate level of care.

The complexity increases with the recognition that while the extent and duration of insurance coverage is determined as a matter of contract, usually in association with employment, the expectations of the insured employee are often framed by other factors, such as unrealistic but widely-held general expectations about access to reimbursed medical care. One thoughtful commentator concluded that these expectations may have moral and legal significance when these expectations are for "continued access to moderate levels of care when they have been encouraged by employers or insurers."

Perhaps the most important set of patient expectations are expectations about economic access to medical services. Patients have expectations about the extent to which their care will be paid for by insurance or other sources. In the United States, these expectations are largely employment-related. Generous health benefits are surely incentives to many peoples' choices of employers or even occupations. Job mobility is discouraged significantly when employees who have employment-based insurance must risk insurance exclusions when they shift to new employers.

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202 Capron, supra note 125, at 742.


204 Id. at 1887-88. Similar expectancies arise in regard to retirement benefits: Retirement benefits are another area in which expectations may extend beyond explicit contractual commitments. Promises to continue to pay health insurance premiums, particularly before Medicare eligibility begins, have been used as inducements for early retirement; a hotly-litigated issue has been the extent to which these promises can be modified in light of rising insurance costs.

Id. at 1888.
Limitations on coverages for certain illnesses, including mental illnesses, have legal, as well as ethical, implications. The vast majority of non-elderly people who have health insurance obtain it as a benefit of employment.\textsuperscript{205} The terms and costs are negotiated by the employer and the insurer. "Americans largely obtain their coverage from employment-based sources, either insured or self-funded. Americans primarily rely on a 'system' of health coverage that is a patchwork of market-driven actors providing 'catch as catch can' coverage dependent not on citizenship or residence, but on the apparently unconnected accident of employment status."\textsuperscript{206} This reality has led some to conclude that employer-provided health insurance contracts may sometimes have the characteristics of contracts of adhesion,\textsuperscript{207} though a contract negotiated by a sophisticated employer may not comfortably fit in this category.\textsuperscript{208} The fact that employers and insurers are setting national health

\textsuperscript{205}In 1993, 61.1\% of non-elderly Americans were covered by employment-based health insurance and 7.7\% were covered by "non-group" (that is, individually purchased) private insurance; 14.1\% were covered by Medicaid or other government program and 16.8\% had no insurance. Jacobi, supra note 67, at 315 n.16 (citing John Holahan et al., A Shifting Picture of Health Insurance Coverage, HEALTH AFF., Winter 1995, at 253-55).

In numerical terms it has been found that: Employer-sponsored health insurance plans are the single largest source of private insurance coverage among nonelderly Americans. In 1991, 140 million Americans under age sixty-five—including nearly eighty-nine million workers—had coverage from an employer-sponsored health plan. Approximately three-quarters of employer-insured workers are covered as a benefit of their own employment; all others—some twenty-one million workers—are covered as the dependent of an employer-insured worker . . .

Chollet, supra note 107, at 315.

\textsuperscript{206}Jacobi, supra note 67, at 317.

\textsuperscript{207}The argument is made:

Many private insurers limit coverage for mental illness to a certain number of days or a set monetary limit. Courts traditionally have considered these limitations to be valid contractual provisions. Under contract theory, the insurer and the insured have bargained freely, and the insurer's responsibilities are limited to the contract's terms. . . . Benefits-limitations clauses may be subject to attack as contracts of adhesion due to the unequal bargaining power between individuals and insurance companies. This argument is most effective when the individual is privately insured. Since the difference in bargaining power is lessened when the insurance company bargains with the employer, the final result may depend on whether the court focuses on the individual employee or the employer. Even a large employer, however, still may be in an unfair bargaining position if the insurance company dominates or monopolizes the local market. In many circumstances, the employer's options are limited to substantially similar plans with restricted mental health care coverage.

Ramage, supra note 156, at 963.

\textsuperscript{208}Havighurst, supra note 166, at 1767 n.27.
policy should be borne in mind as this article continues to investigate the relationship between mental illness and the ADA.

While long-term disability insurance is much less commonly provided as a benefit of employment than is health insurance, disability insurance typically provides vastly inferior benefits for mental, as compared to physical, disabilities. Limitations that accompany long-term disability coverage for mental (but not physical) illness, such as caps on the number of visits to the treating physician, limits on the duration of coverage, or requirements that treatment be provided in an institutional setting, have serious consequences on the individual and family of the insured. In some cases, "[a]fter years of paying for insurance benefits, they find themselves without any income following as little as twenty-four months of coverage." The policies against such limitations and the implications of those policies on access to care, are identical for both health insurance and long-term disability insurance.

V. TITLE I OF THE AMERICANS WITH DISABILITIES ACT

A. Language of the Statute

Title I of the ADA provides as a general rule that:

No covered entity shall discriminate against a qualified individual with a disability because of the disability of such individual in regard to . . . the hiring, advancement, or discharge of employees, employee compensation . . . and other terms, conditions, and privileges of employment. 210

Commentators agree that courts tend to construe insurance contracts as if they were negotiated individually by the insured, rather than by the probably more sophisticated employer. One consequence of this is the application of the doctrine of contra proferentum to construction of the terms of the contract. Contra proferentem ("against the proffering party") interprets an ambiguous term in the manner most favorable to the insured.

The contra proferentem rule is followed in all fifty states and the District of Columbia, and with good reason. Insurance policies are almost always drafted by specialists employed by the insurer. In light of the drafters’ expertise and experience, the insurer should be expected to set forth any limitations on its liability clearly enough for a common layperson to understand; if it fails to do this, it should not be allowed to take advantage of the very ambiguities that it could have prevented with greater diligence.


Whether this doctrine is appropriately applied in ERISA cases (where state law has been preempted) or in ADA cases is a matter of dispute.

209 Giliberti, supra note 180, at 603.

The term discriminate includes:

[P]articipating in a contractual or other arrangement or relationship that has the effect of subjecting a covered entity’s qualified . . . employee with a disability to the discrimination prohibited by this subchapter (such relationship includes a relationship with . . . an organization providing fringe benefits to an employee of the covered entity . . .). \(^{211}\)

A qualified individual with a disability is:

an individual with a disability who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires. \(^{212}\)

**B. Parker v. Metropolitan Life Ins. Co.**

1. Facts

When a person with a total disability brings a Title I claim against an employer which provides long-term mental disability benefits that are inferior to physical disability benefits, the weight of current authority is that the complaint will be dismissed under Rule 12(b)(6) of the Federal Rules of Civil Procedure. Typical reasoning for this result is set forth by the Western District of Tennessee in *Parker v. Metropolitan Life Insurance Co.* \(^{213}\)

Ouida Sue Parker became an employee of Schering-Plough Corporation in 1981. As a benefit of employment, Parker participated in a long-term disability plan administered at least in part by Metropolitan Life Insurance Company, the terms of which (with exceptions not relevant at this point) provided two years of medical benefits for mental or nervous disorders, \(^{214}\) but benefits until age

\(^{211}\)42 U.S.C. § 12112(b)(2).

\(^{212}\)42 U.S.C. § 12111(8).


\(^{214}\)The exceptions extend long-term benefits under certain conditions where the individual was hospitalized for the disorder. In this case the long term disability plan provided:

MENTAL OR NERVOUS DISORDERS. If you are totally disabled due to a mental or nervous disorder your LTD [long term disability] benefit is payable for up to twenty-four (24) months. At the end of twenty-four (24) months of LTD benefit payments, benefits will continue only if you are confined in a hospital or other institution qualified to provide care and treatment for your mental or nervous disorder. Further, if you are confined for at least fourteen (14) consecutive days, your LTD benefit is extended to provide benefits for an additional ninety (90) days after the confinement. If during the additional ninety (90) day period you are again confined in a hospital or institution for fourteen (14) days or more, your LTD benefit will be paid during the confinement and the ninety (90) day period following your release.

_Id._ at 1324.
In October 1990, Parker became disabled due to major depression. As a consequence of this illness she had several hospitalizations, electroshock therapy, and various treatments with Lithium, Elavil, Ativan, and Tegretol. When she became eligible under the long-term disability plan, she received two years of benefits. Thereafter, the disability benefits were terminated although she continued to be disabled, "primarily due to 'major depression,' and secondarily due to 'generalized anxiety disorder.'" One of the reasons for the termination of her benefits was that she was not confined to a hospital at the time the claim for extended benefits was made.

Parker sued both her employer, Schering-Plough, and the insurer, Metropolitan Life Insurance Company, alleging they were in violation of Titles I and III of the ADA, and of ERISA. Parker alleged that Title I of the ADA was violated because the long-term disability plan provided less benefits for people with mental disabilities than for those with physical disabilities. She alleged that Title III of the ADA was violated because she was denied "full and equal enjoyment of the goods, services, facilities, privileges, advantages or accommodations of a place of public accommodation. . . ." Parker alleged that ERISA was violated when she was denied benefits due under the terms of the disability plan since her disability was of a physical, not mental, origin and that this denial was a violation of defendants' fiduciary duties to her.

The same plan provided that persons who were totally disabled due to physical disorders would receive benefits until the age of sixty-five. Parker, 99 F.3d 181, 184 (6th Cir. 1996).

875 F. Supp. at 1324.

Her physician wrote, "Sue continues to show signs of major depression with a great deal of anger, pity, and some suicidal ideation, decreased psychomotor activity, obsessional concern to the point of rumination, which has hindered life efficiency . . . ."

Id.

(Id. (correspondence from Parker's physician).

The plan required a twenty-six week waiting period. Parker, 99 F.3d at 184.

Id. In other communications, Parker's physician opined that she "has a chronic major depression and all evidence indicates that this is a chemical disorder of a deepseated nature." Parker, 875 F. Supp. at 1324-25; see also 99 F.3d at 184.

875 F. Supp. at 1323.

875 F. Supp. at 1330.


Parker, 875 F. Supp. at 1323.

Id. at 1327.

Id. at 1323.
also alleged several common law tort claims. In the district court, she lost on every claim.

2. Analysis: United States District Court for the Western District of Tennessee

Title I of the ADA, which prohibits discriminatory employment practices, requires that "[n]o covered entity shall discriminate against a qualified individual with a disability . . . in regard to . . . terms, conditions, and privileges of employment." Title I is directed toward discrimination in employment. An employer is clearly a covered entity.

There is also authority that an insurer which administers an employer-funded insurance benefit is a covered entity. Metropolitan Life disputed the claim that it was a covered entity. The district court was not required to decide this issue because the court found that Parker was not a qualified individual with a disability.

A qualified individual with a disability is "an individual with a disability who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires." The district court held that Parker was not a qualified individual with a disability because, although she had a disability, her disability was so severe that she was not able to perform the essential functions of her job. The court consulted legislative history to determine that while Parker was a qualified individual at the time she was enrolled in the long-term disability plan, the term qualified refers to "whether the individual is qualified at the time of the job action in question"—in this case at the time of termination of disability benefits.

In short, the very circumstances that qualified Parker to receive disability benefits disqualified her from the protections of the ADA. Parker’s major depression made her disabled in a way that rendered her unable to perform
her job function. Since she could not perform her job function, the benefits of her employment were not protected by Title I of the ADA.233

3. Analysis: United States Court of Appeals for the Sixth Circuit

Parker appealed to the United States Court of Appeals for the Sixth Circuit.234 The three-judge panel rejected each of Parker's Title I arguments. Parker argued that she could sue her employer and insurer under Title I. She relied upon decisions of the First Circuit and the District of Colorado.235 The three-judge panel declined to recognize the two cases as authoritative because neither dealt with the issue of standing to assert a Title I claim. To the contrary, the panel pointed to an Eleventh Circuit case236 and several district court cases237 to support its interpretation of the language of Title I to deprive Parker of a Title I claim.

233 The court states, it may seem undesirable and perhaps unpleasant that a totally disabled individual is not entitled to relief under Title I of the ADA. However, the plain language of the Act clearly indicates that the ADA was designed to afford relief only to those individuals with disabilities who can perform the essential functions of the job that they hold or seek. Id. at 1326 (citing 42 U.S.C. §§ 12112(a) & 12111(8)). The court found support for its holding in Beauford v. Father Flanagan's Boys' Home, 831 F.2d 768 (8th Cir. 1987), a Rehabilitation Act case in which the issue was whether an employee on disability leave who could not perform essential job functions could claim the protection of the Act. The Eighth Circuit held that she could not. Although plaintiff was disabled, she was not otherwise qualified to meet all of a program's requirements. The Parker district court noted, "Because provisions under the ADA are to be interpreted consistent with similar requirements under the Rehabilitation Act, the Beauford court's analysis is instructive in the present case." Parker, 875 F. Supp. at 1325.

234 Parker v. Metropolitan Life Ins. Co., 99 F.3d 181 (6th Cir. 1996). The developing importance of this case is evident from the fact that an amicus brief was filed by several AIDS and mental health interest groups, New York Lawyers for the Public Interest, New York City AIDS Action Council, American Foundation for AIDS Research, American Public Health Association, National Alliance for the Mentally Ill, National Association of Protection and Advocacy Systems, National Minority AIDS Council. An amicus brief was also filed by the EEOC which is charged with enforcement of Title I of the Americans with Disabilities Act, 42 U.S.C. § 12117. Id. at 183.


Parker urged the panel to reconsider the meaning of the statutory language of Title I which was read by the district court to deprive her of standing to proceed. She argued that the critical language of "qualified individual with a disability" should not be read to require a claimant to be able to perform essential job functions at the time the benefit is sought. Rather, she argued, the language should be read to mean that an employee who has qualified for a benefit by becoming employed, participating in a benefit plan, and paying premiums, has a right to retain the employment position of a benefit recipient after becoming disabled. The panel found this argument to be an unpersuasive and convoluted construction of the statute.

Similarly, the panel characterized Parker's argument that adoption of the plain language interpretation suggested by the district court would have the result that "virtually no employee could ever challenge discrimination in the provision of long-term disability benefits," as circular. The panel found that the plain meaning of the statute was clear even if this produced results that undermined the purpose of the Act and perhaps never were considered by its drafters.

Thus the Sixth Circuit three-judge panel agreed with the district court's interpretation of the plain meaning of Title I that:

Ms. Parker was at no time a "qualified individual with a disability." At the time she could "perform the essential functions" of her job, she was not disabled for purposes of her long term disability claim, and therefore was not covered by the Disabilities Act, and at the time her insurance benefits were terminated, she could no longer perform her job.

Plaintiff did not seek an en banc rehearing of the decisions on her Title I claim.

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238 Parker, 99 F.3d at 186-87.
239 Id. at 187.
240 Id. at 186. In its brief, the EEOC argued that because "most long-term disability benefits are reserved for those who are unable to hold any substantial employment for which they are qualified," under the court's interpretation of the term qualified, "virtually no employee could ever challenge discrimination in the provision of long-term disability benefits. . . . [T]he fact that this approach would bar most employees from challenging discrimination in the provision of long-term disability benefits strongly suggests that it is incorrect," because the Disabilities Act's express prohibition against discrimination in fringe benefits would be significantly undermined.
241 Id.
242 Parker, 99 F.3d at 187. The Circuit Court continued, "Such an oversight, however, is for Congress to remedy. We should not try to rewrite the statute in a way that conflicts with what appears to be fairly clear language." Id.
243 Id. at 186.
C. Supporting Title I Decisions

In *Parker* a three-judge panel held that a person who is totally disabled is unable to perform the essential functions of the job and, therefore, is not a qualified individual with a disability entitled to the protection of Title I of the ADA. The consequences of the holding is that a person who becomes totally disabled while employed can never challenge the unequal terms of a disability plan. That the Title I claimant was at one time a qualified individual who was eligible for, and may have contributed in part to, the benefits in question, was held not to change the fact that the plain language of Title I extends its protections only to those who can perform the essential functions of the job at the time the discrimination claim is made.

The Seventh Circuit held similarly in *Equal Employment Opportunity Commission v. CNA Insurance Companies*. Plaintiff Valladares-Toledo was employed by Continental Casualty Company through which she opted to participate in a long-term disability insurance plan funded by employee contributions. Originally the plan provided long-term disability benefits until age 65, but it was modified to limit benefits for mental disability to two years. Several years after the modification plaintiff was "diagnosed with severe depression and bipolar illness." Pursuant to the plan she received benefits for two years before they were terminated. Valladares-Toledo filed a discrimination claim with the EEOC alleging the plan discriminated against employees with mental disabilities in violation of the ADA. The EEOC investigated the claim and later filed a suit on her behalf against CNA.

The primary substantive issue was whether Valladares-Toledo, an employee who was totally disabled, had standing to sue under Title I, even though she was "unable to hold an 'employment position.'" The court first rejected the argument that Valladares-Toledo filled an employment position by virtue of

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244Id. Parker did not seek en banc review of this issue.

24599 F.3d at 186.

246See id. at 186-87.

24796 F.3d 1039 (7th Cir. 1996).

248Id. at 1041.

249Id.

250Id.

251Id.

252EEOC v. CNA Ins. Co., 96 F.3d at 1041. The EEOC's authority to bring the case on behalf of this plaintiff is discussed. Id. at 1041-43.

253The court suggested that while the parties phrased the issue in terms of standing, "the real question here is whether the statute reaches this kind of claim." Id. at 1043.

254Id.
being a recipient of disability benefits. "An 'employment position' is a job," the court stated, and it is only to those who apply for or currently hold a job that Title I applies. It is only to current employees that Title I assures equal access to terms, conditions and privileges of employment, including access to a pension plan. Thus, because Valladares-Toledo's disability made her incapable of holding an employment position, she was not entitled to the protection of Title I.

Furthermore, the Seventh Circuit continued, CNA's plan did not discriminate against disabled employees:

It did not charge higher prices to disabled people, on the theory that they might require more in benefits. Nor did it vary the terms of its plan depending on whether or not the employee was disabled. All employees—the perfectly healthy, the physically disabled, and the mentally disabled—had a plan that promised them long-term benefits from the disability until age 65 if their problem was physical, and long-term disability benefits for two years if the problem was mental or nervous. This may or may not be an enlightened way to do things, but it was not discriminatory in the usual sense of the term.256

A similar holding is found in the Eleventh Circuit's decision in Gonzales v. Garner Food Services, Inc.257 In that case, Bourgeois was an employee of a Hardee's restaurant who received health insurance up to a $1,000,000 lifetime limit. He was diagnosed with AIDS in 1991 and was fired a few months later by his employer who wished to avoid paying future health insurance claims.258 However, Bourgeois continued to receive benefits pursuant to the Consolidated Omnibus Reconciliation Act of 1985.259 In part because of this, defendants changed the health plan in October 1991 to cap benefits for AIDS-related illnesses to $10,000 annual and $40,000 lifetime maximums. Bourgeois had exhausted the limits available and had remaining expenses of $90,000 at the time of his death.260 Gonzales, the administrator of Bourgeois' estate, brought an action alleging that the modification of the plan was prohibited under Title I of the ADA.

The substantive issue of the case revolved around the meaning of the phrase "qualified individual with a disability."261 The court quickly determined that

255 Id. at 1044.
256 Id.
257 89 F.3d 1523 (11th Cir. 1996). This case had a large number of amicus curiae filings including those of the ACLU, AARP, and the EEOC.
258 Id. at 1524.
260 Gonzales, 89 F.3d at 1525.
261 There were other threshold issues in the case. For instance, the benefit plan at issue was modified prior to the date the ADA went into effect but remained in effect thereafter. The ADA states that Title I is not retroactive as to private employers. The court assumed,
although Bourgeois was disabled, he was not a qualified individual with a
disability because his disability made it impossible for him to hold an
employment position. Relying on the legislative history of the Act, the court
concluded that Congress intended to protect only those employees who could
perform the tasks required of them by their employment.

The court discussed at length plaintiff's argument that by the terms of Title
VII and its related cases, the term employee should be extended to include
former employees. The argument was rejected on the ground that the plain
language of Title I extends protection only to job applicants and current
employees capable of performing essential job functions. Since Bourgeois was
not able to do that, he could not seek the protection of Title I.

Several district courts have come to the same conclusion. For example, in
Esfahani v. Medical College of Pennsylvania, the plaintiff was a professor who
had been employed by the medical college and the university since 1978. Since
1981 the defendants had been aware that Esfahani was diagnosed as suffering
from "bi-polar affective disorder (formerly known as manic depression)." As
a benefit of employment Esfahani received the opportunity to participate in a
long-term disability plan by making monetary contributions to it. The medical
college provided him with a document describing the plan and stating that, in
the event of long-term disability, participants would be covered until age 65. In
1993 Esfahani became completely disabled as a result of his mental disorder
and became eligible to receive long-term disability benefits. Shortly thereafter
he was notified that he would continue to receive benefits only for two years
because his disability was a mental or nervous condition.

Esfahani filed a complaint against defendants under ERISA, the ADA, and
state civil rights law. Defendants' motion to dismiss argued that Title I of the
ADA did not apply because Esfahani's total disability made him unqualified
to work and thus unable to meet the prerequisites for Title I protection. Esfahani
counteracted that before he became totally disabled he was a qualified employee

for purposes of its analysis, that a violation that began before the Act went into effect,
but continued after it became effective could constitute a continuing violation. id. at
1525.

262Title VII of the Civil Rights Act is relevant because the EEOC, which enforces Title
I, suggests in Interim Guidance that Title I should be construed by analogy to Title VII
and the term employee should have the same meaning in Title I and Title VII. 29 C.F.R.


264Id. at 834.

265While other employee benefit documents were referred to, plaintiff was not able
to acquire them and he alleged they did not exist. id.

266Id. at 835.

267Id. Defendants moved to dismiss all claims except the claim which alleged that its
failure to provide plaintiff with an adequate description of the benefit plan violated
ERISA duties. id.
with a disability and that during this period the discriminatory policy was put into effect. This argument, if accepted, would establish that he possessed the three qualities that are required by Title I: disabled, able to perform the functions of his employment position, and treated differently.

The court easily held that when Esfahani became totally disabled he lost his classification as a qualified individual with a disability and also the protection of Title I. The court also found that while Esfahani was a qualified individual with a disability—before he became totally disabled—the plan in which he participated had a disability-based distinction which could be challenged under the ADA. Whether that disability-based distinction came within the safe-harbor provisions of the Act could not be determined on a motion to dismiss.268

D. Conflicting Title I Decisions

There is authority contrary to the Title I decisions set forth in the preceding section. For example, in Carparts Distribution Center, Inc. v. Automotive Wholesaler's Ass'n of New England,269 Senter, the insured individual, was sole shareholder and president of Carparts Distribution Center. Carparts provided insurance to its employees by participating in the Automotive Wholesaler's Association of New England Health Benefit Plan, a self-funded medical reimbursement plan.270 Senter was enrolled in the plan beginning in 1977. In 1986 he was diagnosed as infected with HIV virus and in 1991 he was diagnosed with AIDS.271 In 1990 the insurance plan was amended to limit lifetime benefits for AIDS-related illnesses to $25,000 while maintaining a $1,000,000 lifetime benefit for other physical illnesses.272 As a consequence of this change in the plan, much of the treatment Senter received during his last illness273 was not paid by the plan. Senter and Carparts brought suit against

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268Esfahani, 919 F. Supp. at 836. Several other issues were presented in the case, including whether ERISA preempted the state human relations claims. In resolving this issue, the court explained the scope of ERISA preemption and why the ADA applies to ERISA plans. ERISA preempts state law that relates to an employee benefit plan that comes within ERISA's scope. State law relates to an employee benefit plan if the state law directly or indirectly regulates the plan. If the state law only regulates the insurer then the state law does not relate to an employee benefit plan. On the other hand, ERISA does not exempt federal laws. Some federal laws, including the ADA, specifically preserve nonconflicting state laws. "[S]tate laws that are co-extensive with federal laws are non-preempted under ERISA. By the same token, 'state laws [that] prohibit employment practices that are lawful under' federal law are properly pre-empted. Further, a state law can have portions of it pre-empted and portions of it non-preempted." Id. at 837.

26937 F.3d 12 (1st Cir. 1994).

270Id. at 14.

271Id.

272Id.

273Senter died in 1993 while the suit was in progress. Id.
the plan and the association alleging that the reduction in benefits, made with knowledge of his illness, was a violation of Title I and Title III of the ADA.274

The United States District Court for the District of New Hampshire had dismissed the claims, holding that Title I did not apply because neither the benefits plan nor the association that authorized it was an employer within the meaning of that title. It also dismissed the Title III claim, finding that neither defendant was a public accommodation.275

The United States Court of Appeals for the First Circuit held that the district court's "dismissal was erroneous as a matter of law," and undertook to provide guidance on the scope of the ADA.276 The First Circuit determined that the provisions of Title I are not limited to the direct employer of a qualified individual with a disability. By consulting parallel language in Title VII of the Civil Rights Act,277 as well as Interpretive Guidance issued by The EEOC for Title I,278 the court determined that both the plan and the association would be

274Carparts, 37 F.3d at 14-15. This is a simplified statement of the procedural course of this case. The case originally had been filed in state court alleging only state claims. The ADA went into effect ten days after the complaint was filed. The claim was that the plan breached its contractual obligation insofar as it failed to provide benefits to cover Senter's non-AIDS related treatments. Carparts' claim was that the plan's "discriminatory provision... rendered Carparts responsible for payments to health care providers on Senter's behalf and effectively put Carparts out of compliance with anti-discrimination laws, subjecting Carparts to potential liability." Id.

The defendants removed the case to federal court because the issues raised were preempted by ERISA. In the federal court, plaintiffs moved to amend the complaint to allege ADA violations. Defendants' objection to this motion was treated by the district court as a motion to dismiss under Fed. R. Civ. P. 12(b)(6). Dismissal was granted even though the district court did not give plaintiffs an opportunity to address the potential dismissal.

The First Circuit held "[t]he [district] court's failure to give such notice alone justifies reversal of this case." Id. at 15. The circuit court vacated the order dismissing these claims and remanded them to the district court for reconsideration in light of its determination that the ADA must be construed more broadly. Id. at 21.

275Id. at 15. "The district court interpreted the term 'public accommodations' as 'being limited to actual physical structures with definite physical boundaries which a person physically enters for the purpose of utilizing the facilities or obtaining services therein.'" Id. at 18.

276Carparts, 37 F.3d at 15. The court stated,

[w]e also find, however, that the court's dismissal was erroneous as a matter of law. The district court erred by interpreting Title I and Title III of the ADA to have excessively limited applications. Questions regarding the proper interpretation of the ADA are sure to arise on remand. Therefore, we feel that timely guidance is appropriate. Id. (citations omitted).

27742 U.S.C. §§ 2000e-1 - 2000e-17 (1964). Title I of the ADA states that the remedies and procedures of Title VII of the Civil Rights Act shall apply to Title I discrimination claims.

278While the interpretive guidelines are not binding on the court, they do "constitute a body of experience and informed judgment to which courts and litigants may properly resort for guidance," Carparts, 37 F.3d at 16, quoting Meritor Savings Bank, FSB v. Vinson,
considered Title I employers under several circumstances. If, for instance, "with respect to his employee health care coverage . . . they exercised control over an important aspect of his employment," the defendants would come within the definition of employer. This issue was remanded to the district court for a factual determination of whether defendants came within the definition of employer in Title I.

The Third Circuit, in Ford v. Schering-Plough Corp., further supports the position that Title I allows review of disparate treatment of physical and mental illness in regard to employer-provided long-term disability insurance benefits. On facts remarkably similar to those of Parker, the court rejected assertions by the employer, Schering-Plough, and the carrier, Metropolitan Life Insurance Co., that plaintiff had no standing to bring a discrimination claim. The court concluded that plaintiff had standing because she was injured by the termination of benefits, her injury could be redressed by a favorable decision, and her interests were within the protective zone of the ADA. The court recognized that the term "qualified individual with a disability" creates a "disjunction" between Title I rights and the statutory language.

The court found that the statutory language was ambiguous and resolved the ambiguity through reliance on Title VII decisions. The Third Circuit reasoned that:

[The ADA's proscription of discrimination in fringe benefits generates the need for disabled individuals to have legal recourse against such discrimination and exposes the temporal ambiguity in the ADA's definition of "qualified individual with a disability,"] We resolve this ambiguity in favor of a broad temporal interpretation of [the term] that disabled former employees, no longer able to work . . . can sue their employers concerning alleged discrimination in their package of disability benefits.

With the crossing of this threshold issue, the court moved to the substantive question of whether the disparate treatment constituted Title I discrimination. Regrettably, the court determined that the inferior benefits provided for disability related to mental disability was not actionable discrimination.


279 Carparts, 37 F.3d 12 at 17. Moreover, "If [the association and the plan] exist solely for the purpose of enabling entities such as Carparts to delegate their responsibility to provide health insurance for their employees, they are so intertwined with those entities that they must be deemed an 'employer' for purposes of Title I of the ADA." Id.

280 145 F.3d 601 (3d Cir. 1998).

281 Id. at 606.

282 Id. at 607, relying on Robinson v. Shell Oil Co., 519 U.S. 337 (1997), while rejecting the reasoning of cases such as EEOC v. CNA Ins. Cos., 96 F.3d 1039 (7th Cir. 1996), and Gonzales v. Garner Food Services, Inc., 89 F.3d 1523 (11th Cir. 1996). Id. at 606-08.

283 Id. at 608.
Despite the two year recovery limitation, the court reasoned that, as this term applied to all employees, it was non-discriminatory.\textsuperscript{284} The ADA "does not contain parity requirements" and Congress has not enacted any change in the ADA to impose such requirements.\textsuperscript{285}

In \textit{Schroeder v. Connecticut General Life Insurance Co.},\textsuperscript{286} plaintiff was an employee of defendant General Tire Company, and a participant in an employee welfare benefit plan which provided various insurance programs. He enrolled in a long-term disability plan offered by the Equitable Life Assurance Society under which he made all premium payments through payroll deduction. Equitable delegated administration of the policy to Equicor, Inc., which, in turn, delegated administration to Connecticut General Life Insurance Co. (CIGNA).

Schroeder was hospitalized in 1990 with a heart condition and had not worked since. CIGNA paid disability benefits for two and a half years then terminated benefits because it determined that because Schroeder's was a mental, not a physical, disability. The policy limited mental disability benefits to 30 months. Schroeder requested reconsideration, saying any mental condition he had was secondary to a physical problem with his heart. When CIGNA refused to extend benefits, Schroeder sued the employer and all three insurers alleging that all defendants were in violation of Title I of the ADA and alleging related state law claims.\textsuperscript{287} The defendants moved for summary judgment.

Defendants' first defense was that the ADA did not apply to them. The United States District Court for the District of Colorado disagreed and held that Title I applied to General Tire because the disability insurance policy was part of the package of benefits it made available to its employees. Title I applied to the remaining defendants because of their contractual arrangement with General Tire.\textsuperscript{288}

Defendants then argued that Title V, which provides a safe harbor provision for insurers,\textsuperscript{289} precluded the Title I claim. The district court held to the contrary. Citing legislative history and regulatory language, the court held that

\textsuperscript{284}Id. at 608-10.
\textsuperscript{285}\textit{Ford}, 145 F.3d at 610.
\textsuperscript{287}Again this is procedurally simplified. Plaintiff originally sued in state court alleging various contract claims and ADA claims, but not making any ERISA claim. The defendants removed the case to federal court on authority of ERISA. \textit{Id.} at *2. As a preliminary matter, the court determined that claims related to the disability plan were preempted by ERISA and they were dismissed. Plaintiff was given leave to amend his complaint to state an ERISA claim. \textit{Id.} at *2-3.
\textsuperscript{288}\textit{Id.} at *3.
\textsuperscript{289}42 U.S.C. § 12201(c) (1990).
Title V requires insurers to provide equality of treatment to disabled persons unless actuarial principles or reasonably anticipated experience justify disparate treatment. Thus, Title V provides an affirmative defense, not an exemption from suit.

The court granted defendants' motion for summary judgment as to the state actions but granted plaintiff permission to amend the complaint to include a violation of ERISA. The final outcome of the ADA and ERISA claims is not yet known.

In the preceding section of this article, the Eleventh Circuit's Gonzales decision was discussed. The majority in that case held that the plain meaning of Title I limits its scope, but a vigorous dissent in Gonzales disagreed with the majority that the plain meaning of the statute limits Title I protection to current employees and "excludes retirees and other former employees." The dissent noted that the general section of the Act refers to individuals, rather than employees. It also noted that while a section listing actions which are considered discriminatory includes some actions that are typically carried out by employees, the list is "expressly nonexclusive [and] the focus of the subsection is on the description of actions that constitute discrimination, not on the persons protected by the Act. In any event, not all of the descriptions refer to employees." The dissent noted the broad remedial purpose of the ADA and that its scope includes fringe benefits such as profit-sharing plans and health benefit plans. The dissent further detailed legislative history, EEOC regulations, Title VII and case law to support its conclusion that Title I does protect former employees. Finally, the dissent appealed to common sense:

A retired or former employee ... has already performed all of the functions expected of him with respect to the job he occupied before retirement. Under the company's plan, the only additional "functions" expected of ... former employees [are] to make the appropriate election, pay the premiums, etc. Fringe benefits ... are all part of the overall compensation package provided for employees as consideration for their service during their active years with the


291The dissent also "clarified" the conduct of the defendant, stating that defendant's actions "would clearly be unlawful now that the ADA is in effect." 89 F.3d 1523, 1531 (11 Cir. 1996)(Anderson, J., dissenting). The dissent makes clear that at the time the defendant should have been taking steps to come into compliance with the ADA, it was taking discriminatory action against a disabled employee. The dissent suggested that "the majority sees 'plain meaning' when there is none." Id. at 1536.

292Id. at 1531.

293Id. at 1532 (quoting 42 U.S.C. § 12112(a)).

294Id. (quoting 42 U.S.C. § 12112(b)(4)&(6)).

295Gonzales, 89 F.3d at 1532 (Anderson, J., dissenting).
company. Post-employment benefits are like deferred compensation, and are expected to be enjoyed during the post-employment years.... Former employees... are not expected to perform the functions of the jobs they previously held before retirement. Rather, they are expected to meet whatever criteria are mandated by the fringe benefit plan for the accrual and continuation of coverage.... 

An earlier case held out some promise to Title I plaintiffs. In Northern v. City of Chicago,297 former police officers who were retired and receiving disability pensions claimed violations of the ADA because the benefits they received were changed to require them to pay for their health insurance, while officers who were not retired were not required to pay for their health insurance.

The City of Chicago moved to dismiss on the ground that Title I does not apply to former employees. The court denied the motion on the ground that the Seventh Circuit had held "that retirement benefits are within the 'compensation, terms, conditions, or privileges of employment' covered under Title VII."298 The court also noted that the Seventh Circuit had "held that being an employee is not a sine qua non for maintaining a suit against an employer; rather there must be an "employment relationship" in order to maintain a suit."299 The district court noted that while the cases upon which it relied were Title VII cases, the almost identical language of Title I and Title VII, and the fact that Title I incorporates parts of Title VII by reference make the reliance justified.300 Finally, the court concluded that "because it granted the plaintiffs the right to sue, the EEOC apparently viewed plaintiffs' claims as covered under the ADA."301 The court said it was too soon to tell whether the ADA applied to disability retirees.

A broad reading was given to the phrase "otherwise qualified employee" in Graboski v. Giuliani, decided by the United States District Court for the Southern District of New York.302 The case was brought by disability retirees who claimed state legislation, which allowed only service retirees to have access to supplemental pension benefits, violated Titles I and II of the ADA and the ADEA. In defense to the Title I claim, defendants argued that because plaintiffs were disability retirees they were not able to perform the essential functions of employment and hence were not qualified individuals with a disability. In

296 Id. at 1535.
298 Id. at 236 (citing Bartmess v. Drewrys, 444 F.2d 1186, 1189 (7th Cir. 1971)).
299 Id. (citing Doe on behalf of Doe v. St. Joseph's Hospital, 788 F.2d 411, 422-25 (7th Cir. 1986)).
300 Id. at n.2.
301 Id. at 236.
addition, the defendants argued that former employees were excluded from coverage. The court did not agree. It noted,

[T]he City argues that once plaintiffs retired on the basis of disability, the ADA no longer requires that they be treated even-handedly.

Such a crabbed view of the ADA's coverage would undermine the statute's unambiguous remedial purpose. As certain fringe benefits (such as pensions and health insurance continuation) are meaningful only post-employment, it is only logical that the statute's coverage reaches the period when the employment benefits are to be reaped.

The court then elaborated upon its reasoning, recognizing that the term employee is used both in Title I of the ADA and in Title VII of the Civil Rights Act. The court noted that Title VII is incorporated by reference into sections of Title I, including the definition of employee. Regulations and legislative history demonstrate that the term employee is to have the same meaning in both Acts. Title VII litigation has established that "discrimination in connection with post-employment benefits is actionable by former employees under Title VII," and the use of the words otherwise qualified in Title I does not place its protection beyond the reach of former employees. The court expressly declined to follow the holdings of the Eleventh Circuit in Gonzales and the district court in Parker which held a former employer has no standing to sue under Title I. However, while the Court recognized that the former employees in Graboski had standing to sue, they failed to make a showing of discrimination prohibited by the ADA.

Prohibited discrimination was found, and damages were awarded, in Lewis v. Aetna Life Insurance, Co., where, at trial, the defendant employer, KMart Corporation, did not contest plaintiff's claim of disparate treatment in benefits for physical and mental disabilities and acknowledged the absence of any sound actuarial practices which would support the disparate treatment, but claimed that there was no liability under Title V's safe harbor provision as the disability plan had been approved by the Virginia Department of Insurance. A second line of defense asserted that because defendant offered disability benefits prior to enactment of the ADA, it could not be liable under Title I. Both arguments were rejected. The court determined that, in the absence of

303 ld. at 266.
304 ld. (collecting cases). The court noted that the Fourth and Seventh Circuits reject this view.
305 The court also noted that former employees may also challenge post-employment benefits under the ADEA. Id. at n.11.
307 ld. at 746-47.
308 ld. at 747-48.
309 ld. at 748.
actuarial or other justification for the disparate and inferior treatment, the safe
harbor provision was not applicable as the plan violated Title I "by offering
Lewis a benefit plan which discriminates against him on the basis of his mental
disability."\footnote{10}

This decision is notable not only because a totally disabled former employee
was successful in overcoming the threshold standing issue, but also because
plaintiff prevailed at trial. This decision will hopefully support similar results
where proof of discrimination can be established.\footnote{11}

\section*{E. Analysis of Title I Issues}

An individual with a long-term disability who claims to have been
discriminated against in violation of Title I of the ADA must first demonstrate
he is an intended beneficiary of the Act. As has been demonstrated in the
preceding section, the Sixth, Seventh, and Eleventh Circuits and the United
States District Court for the Eastern District Pennsylvania have held that a
person with a total disability, who can no longer work, cannot bring a
discrimination claim under Title I because only qualified individuals with
disabilities may do so: individuals who can perform the essential functions of
the job. However, \textit{Northern, Graboski}, and the \textit{Gonzales} dissent provide more
persuasive reasons why, as a matter of law and common sense, Title I must be
available to challenge long-term disability benefits. Furthermore, the EEOC
appears to believe that Title I does protect totally disabled persons and appears
to be pressing that claim.\footnote{12}

Arriving at the correct interpretation of the scope of Title I starts with the
language of the Act.\footnote{13} The courts which have excluded totally disabled
individuals who cannot continue to work from the protection of Title I have
concluded that the plain language of the statute requires the claimant to be able
to perform the essential functions of the job at the time the claim of
discrimination is made. Once a court has decided that the language of the
statute is clear, there is no need to consult additional authority.

\footnote{10}\textit{Id.} at 749.

\footnote{11}As an appeal is pending, the persuasiveness of this decision remains problematic.

\footnote{12}It has been reported that the EEOC sued Chase Manhattan Corporation in
September of 1997 alleging that the benefit plans it offers its employees provide
dramatically inferior benefits for mental disabilities as compared to physical disabilities.
The case seems to be a Title I case because the argument being pressed by the EEOC is
reported to be "that because a person is technically still employed while he or she is on
disability, early termination of mental-health benefits is effectively the same as early job
termination," and because the employer is named as one of the defendants. On the other
hand, the case may be a Title III case insofar as the issue is reported to be a direct
challenge to \textit{Parker v. Shering-Plough}. Glenn Burkins, \textit{Chase Faces Suit over Benefits to

\footnote{13}See \textit{supra} that accompanying notes 210-12 for statutory language of 42 U.S.C.
\textsection{12212(a), 12112(b)(2), and 12111(8).}
The position of this article is that, contrary to the majority view, the language of the statute is ambiguous with respect to long-term disability benefits. The ambiguity arises from several sources. First, the language of the Act itself does not limit its scope to employees. The ADA is intended to protect individuals, not only employees. In at least some circumstances Title I specifically protects individuals who are not, strictly speaking, employees. For example, although job applicants are not employees, Title I clearly prohibits discrimination against disabled job applicants who can perform the essential functions of the position they seek. Although individuals who have been discharged are not employees, those who have been terminated for discriminatory reasons are expressly protected by Title I.

The employee who receives long-term disability benefits upon becoming disabled is not a stranger to the employer. The benefits were earned, and often partly paid for, by the employee while in an employment relationship with the employer. This kind of employment relationship should be enough to draw the protection of Title I. The claimant should not have to be a current employee, especially where the benefits involved are intended to be used after employment. Graboski held that plaintiffs who were retired due to their disabilities could sue under Title I when their employer refused to allow them

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314 42 U.S.C. § 12101(a) refers repeatedly to individuals who have experienced discrimination. 42 U.S.C. § 12111(4) defines employee as "an individual employed by an employer."

315 "No covered entity shall discriminate against a qualified individual with a disability because of the disability of such individual in regard to job application procedures ..." 42 U.S.C. § 12112(a).

316 "No covered entity shall discriminate against a qualified individual with a disability because of the disability of such individual in regard to ... discharge of employees ..." 42 U.S.C. § 12112(a).

The dissenting judge in Gonzales concluded that former employees are not excluded from the scope of Title I:

The majority emphasizes the language of § 12112(b) which sets out a nonexclusive list of actions (or types of action) which constitute discrimination. ... The majority takes comfort in the fact that many of the actions described refer to employees or applicants. Not only is this list expressly nonexclusive, but the focus of the subsection is on the description of the actions that constitute discrimination, not on the persons protected by the Act. In any event, not all of the descriptions refer to employees or applicants. See § 12112(b)(4)&(6).

89 F.3d at 1532 n.2.

317 While 41% of the employees in medium and large private businesses receive long-term disability insurance as a benefit of employment, 27% of the employees contribute to the plan. U.S. Dep't of Commerce, STATISTICAL ABSTRACT OF THE UNITED STATES 431 (116th ed. 1996) (Table 671: Employee Benefits in Private Establishments: 1993 and 1994) Among the 30% of state and local government employees who receive long-term disability insurance as a benefit of employment, 23% contribute to the plan.

318 Northen, 841 F. Supp. 234, 236.
supplemental benefits that were allowed to employees who retired for nondisability-related reasons.319

It is significant that by disallowing such claims, it is the insurer who benefits. Often both the employer and the employee have contributed to long-term disability insurance. To deny the employee/beneficiary of the insurance the opportunity to collect on it, for reasons not related to the genuineness of disability, creates a windfall to the insurer.

A second source of ambiguity in the definition of qualified individual with a disability lies in matters of timing. In the context of long-term disability insurance, courts have read the term to mean that the claimant must be able to perform the essential functions of the job at the time the claim of discrimination is made. The definition could just as easily be read to mean that the claimant must have been able to perform the essential functions of the job at the time the insurance was granted as a benefit of employment.

Certainly, this construction is implicit in the way in which a disabled employee who is afforded health insurance is viewed. Such a person may contract an illness or require surgery that causes him to be absent from work for an extended period of time. No one can logically assert that such a person has no standing to challenge the terms of the insurance coverage because he cannot work while he recovers from his illness or surgery. Even though it is true that most employees drawing health insurance benefits are expected to return to work, while most employees drawing long-term disability insurance benefits are expected not to return to work, future expectations should not determine standing to challenge the terms of a benefit awarded while one was a qualified individual with a disability.320

Whether an employee who has received long-term disability insurance as an employment benefit can seek the protection of Title I after he develops a disability and is unable to continue to work, is simply not clearly indicated in the statute. Insofar as the language of the statute is unclear or ambiguous, it is appropriate to turn to the purpose and legislative history of the Act and to agency actions for guidance. When one does that, it becomes difficult to deny totally disabled individuals the protection of Title I.

The findings and purposes of the ADA are so prominently articulated in the statute that it is beyond question that the ADA is a remedial statute intended to eliminate discrimination against individuals with disabilities.321 Like any

319Graboski, 937 F. Supp. 258, 266.

320If the long-term disability contract itself made reference to prospects of rejoining the workforce in the future, then the claimant's employment status at the time the benefit is demanded and the courts' interpretation of the qualified individual with a disability language of Title I would make more sense. But the obvious reality is that the premiums for long-term disability insurance are calculated in anticipation of the insured not returning to work.

remedial statute, it should be liberally construed. As was noted by the Gonzales dissent, "the denial of claims of former employees with respect to fringe benefits would seem to intrude more severely on the obvious congressional intent to protect employer-provided fringe benefits. As a matter of common experience, fringe benefits are designed and provided primarily for the post-employment years."

It is also understood that the ADA was enacted, in part, because prior statutory schemes intended to redress discrimination against the disabled were not effective. Therefore, care should be taken not to force the ADA into the parameters of less effective earlier efforts to provide civil rights to disabled individuals.

The close relationship of Title I of the ADA and Title VII of the Civil Rights Act, with respect to powers, remedies, procedures, and enforcement further argues for understanding the scope of Title I to include totally disabled employees. The relationship of the two statutes, which is established by the ADA, allows courts interpreting aspects of Title I to refer to Title VII cases for persuasive authority.

As the court in Graboski showed, Congress intended

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323 89 F.3d 1523, 1534 (Anderson, J., dissenting).

324 McFadden, supra note 25. Unlike other current disability statutes, such as the Rehabilitation Act, the Air Carrier Access Act, and the Fair Housing Amendments Act, which only ban specified discriminatory acts in narrowly defined areas such as employment, air travel, and housing, the ADA is designed to provide the disabled with comprehensive protection against discrimination in all arenas of life.

Id. at 485. See also Arney, supra note 28. (While ADA is modeled after Rehabilitation Act and Fair Housing Amendments Act, courts have inconsistent interpretations.); David Orentlicher, Destructuring Disability: Rationing of Health Care and Unfair Discrimination Against the Sick, 31 HARV. C.R.-C.L. L. REV. 49 (1996) (Courts have not interpreted anti-discrimination statutes in a way which fulfills congressional intent.)

325 This problem is manifested where cases decided under the earlier statutes are used more like controlling authority than persuasive authority in ADA cases. Thus, while it is appropriate to consider the meaning of the term subterfuge by reference to the ADEA in Public Employees Retirement System of Ohio v. Betts, 492 U.S. 158 (1989) and to take Alexander v. Choate, 496 U.S. 287 (1985) or McGann v. H & H Music Co., 946 F.2d 401 (5th Cir. 1991), into account in various disparate benefit situations, they should be considered to interpret standards inferior to those established by the ADA.

326 "The powers, remedies, and procedures set forth in [Title VII of the Civil Rights Act] shall be the powers, remedies, and procedures this subchapter provides . . . Agencies with enforcement authority for actions which allege employment discrimination under [Title VII of the Civil Rights Act] shall develop procedures . . ." 42 U.S.C. § 12117(a)&(b).


both Title I and Title VII to share the same definition of employee. In Title VII cases, former employees have been held to be statutory employees.329

The Gonzales dissent noted that the Eleventh Circuit has held Title VII allows a former employee to sue a former employer even though the statute refers only to employees and applicants for employment.330

It is significant that Congress enacted the ADA in 1990. Congress is deemed to legislate against the background of the federal common law. When Congress enacted the ADA in 1990, it was clearly established Title VII case law that the term "employee" includes former employees. Congress is deemed to be familiar with such case law. In the ADA, Congress used the same definition of "employee" that it used in Title VII. The text of the ADA expressly refers to Title VII, and the legislative history clearly indicates a congressional intention to incorporate the established Title VII meaning for the term "employee."331

The Gonzales dissent also pointed out that the term employee is broadly interpreted to include a former employee under both the ADEA332 and the Rehabilitation Act.333 Given this statutory and decisional background of terms used in common, the dissent concluded that Title I challenges could be brought by former employees—those who became totally disabled while employed.

In addition, agency action supports the more expansive reading of Title I. EEOC regulations provide that the ADA should not apply a lesser standard against discrimination than does the Rehabilitation Act.334 The regulations provide definitions of terms such as employee ("an individual employed by an employer")335 and qualified individual with a disability ("an individual with a disability who satisfies the skill, experience, education and other job-related requirements of the employment position such individual holds or desires . . . ").336 While the regulations do not address the question of whether an em-

329 Graboski, 937 F. Supp. at 266.
330 Gonzales, 89 F.3d at 1533 (Anderson, J., dissenting) relying on several Title VII cases including Bailey v. USX Corp., 850 F.2d 1506 (11th Cir. 1988).
331 Id. at 1534.
332 Gonzales, 89 F.3d at 1533 (Anderson, J., dissenting) relying on EEOC v. Cosmair, Inc., 821 F.2d 1085 (5th Cir. 1987).
333 Gonzales, 89 F.3d at 1534-35 (Anderson, J., dissenting). The Rehabilitation Act is significant in this context because the ADA was intended to be interpreted with reference to section 504 of that Act which prohibits discrimination against otherwise qualified handicapped individuals in federally funded programs.
335 29 C.F.R. § 1630.2(f).
336 29 C.F.R. § 1630.2(m).
ployee who has become totally disabled can claim Title I protection, EEOC Interpretive Guidance does provide some help:

The determination of whether an individual with a disability is "qualified" is to be made at the time of the employment decision. The determination should be based on the capabilities of the individual with a disability at the time of the employment decision, and should not be based on speculation that the employee may become unable in the future or may cause increased health insurance premiums or workers compensation costs.

This Guidance establishes that the Act provides protection at the time an employee is hired. Changes in ability do not disqualify an employee from the protection of Title I.

Third, common sense and intuition require that employees who become totally disabled must be able to claim the protection of Title I:

It would be counter-intuitive, and quite surprising, to suppose ... that Congress intended to protect current employees' fringe benefits, but intended to then abruptly terminate that protection upon retirement or termination, at precisely the time that those benefits are designed to materialize. The structure of the statute, in clearly extending protection to fringe benefit plans, indicates that Congress intended protection for those routinely and commonly covered by such employer-provided plans.

Generally, disability insurance is available only to current employees, not to employees who have been terminated. Becoming disabled (unable to work)
does not, as a matter of insurance law, cause the employee to lose his status as an employee entitled to the benefits of a disability policy. It could hardly be otherwise: if one became a terminated employee as soon as one became unable to work because of a disability, no disability insurance policy would ever have to pay.

The purpose of disability insurance is to protect the income of the insured employee if he becomes disabled. In the event an insured employee does become disabled—that is, when sickness or injury cause him to be unable to perform substantially all the material acts of an occupation—he has a legal right to recover some predetermined portion of his wages under the insurance contract.

Furthermore, an employee can recover disability insurance even if there is hope for recovery where it appears that his total disability will continue for an uninterrupted period of time (or the time set by the contract). If the disability is cured and the insured becomes able to perform substantially all the material acts of an occupation, the disability benefits will cease. In this sense, employees who receive disability benefits remain employees just as employees who receive health insurance benefits remain employees, although they may be hospitalized for some period of time during which they cannot perform the essential functions of the employment position. An employee who is hospitalized for hip-replacement surgery and spends several months recuperating often qualifies to receive health insurance even though he is not able to perform the essential functions of the employment position during the treatment and recovery period. While the anticipated period of inability to work may be different, the relationship of the individual to the employment position is the same in both cases: neither the individual claiming health insurance benefits nor the person claiming disability benefits can perform the essential functions of the employment.

Title I should afford no less protection against discrimination to an employee who cannot work because he had a hip replacement (which might be covered by health insurance) and an employee who cannot work because of a long-term illness (which might be covered by disability insurance). Both received access to the benefits at a time they were qualified individuals who could perform the essential functions of the employment position. Both forms of insurance were provided in anticipation of a time when the employees might not be able to work. Both employees became unable to perform those functions when they had surgery or developed the long-term illness. The potential length of time the employee might be unable to work (temporarily, in the case of the employee who had the surgery—permanently, in the case of the employee who had the long-term illness), is not relevant to measuring the scope of Title I. When the benefits were conferred, the rights and expectations with respect to the insurance were created or vested. At that time the insured was able to perform the essential functions of the employment position.

34015 Anderson & Rhodes, supra note 130, § 53:114 at 162.
It may be argued that treating mentally and physically disabled employees differently is justified for one reason or another—for instance, mental illness is hard to define, or the success of treatment is difficult to assess, or the cost of equal coverage would be prohibitive. But these arguments address matters that arise in application of the safe harbor and subterfuge sections of Title V, not the threshold requirements of Title I. The "legality" of discrimination in disability insurance based on mental, as opposed to physical, illness should not be based on the employee's lack of status as a qualified individual with a disability.

It must be kept in mind that the issue being discussed here is a threshold issue: one of access to the courts under Title I of the ADA. The majority view is that claimants who have become totally disabled and cannot work after being employed are not protected by Title I. Such persons are precluded from presenting claims that long-term disability insurance benefits impermissibly discriminate on the basis of type of disability. Only if courts accept the argument put forward here, that Title I should be extended to cover totally disabled employees who can no longer work, will such claimants then be allowed to argue the second issue: that the long-term disability policies which provide inferior benefits for mental disabilities are discriminatory in a way that is prohibited by the ADA.

This second issue presents separate problems to a totally disabled employee, especially one who has a mental disability. The language of the ADA and of case law developed under the Rehabilitation Act and other statutes seems to approve disparate benefits for physical and mental illnesses in health insurance policies offered by employers under circumstances where the disparity can be supported by actuarial analysis and where the disparity is not an intentional subterfuge of ADA policies. It is here that the differences between health insurance and long-term disability insurance are important. While actuarial analysis and the creation of risk pools might be relevant in projecting the likely cost of an employee's health care, and while the projected likely cost of an employee's health care might be relevant in underwriting health insurance, this is not true of long-term disability insurance. Long-term disability insurance protects against loss of income regardless of actual loss of the insured.

Long-term disability insurance benefit awards are not based on the type of disability. That is, regardless of an eligible employee's condition, that person receives a specific income based on a percentage of the employee's previous wages. Variations in symptoms or treatment regimens are irrelevant to the insurer, who does not vary the amounts paid based on any factors related to the disability. Accordingly, insurers cannot justify limits for persons with mental disabilities based on the cost of the benefit.\(^\text{341}\)

The EEOC has taken action with respect to disparate health-insurance benefits, creating large hurdles for the claimants in the disparate benefit claims. In Interim Policy Guidance, the EEOC notes that some employer-provided

\(^{341}\)Giliberti, supra note 180, at 603-04.
health insurance provides inferior coverage for mental, compared to physical, conditions:

[S]uch broad distinctions, which apply to the treatment of a multitude of dissimilar conditions and which constrain individuals both with and without disabilities, are not distinctions based on disability. Consequently, although such distinctions may have a greater impact on certain individuals with disabilities, they do not intentionally discriminate on the basis of a disability and do not violate the ADA.\(^{342}\)

This Interim Guidance, though lacking the force of regulations, presents a significant barrier to individuals with mental disabilities who wish to challenge the terms of a health insurance contract.

Notice, however, that the Interim Guidance applies only to health insurance. It does not apply to disability insurance. The EEOC has taken no action with respect to the latter, except, significantly, to challenge disparate long-term disability benefits in court. Neither can the logic of the Interim Guidance be transferred to disability insurance, because in disability plans, all the covered individuals are disabled. Selecting for inferior treatment only those with mental disabilities is intentional discrimination on the basis of a disability. This is a violation of the ADA.\(^{343}\)

VI. EMPLOYEE RETIREMENT INCOME SECURITY ACT AND PARKER V. METROPOLITAN LIFE INS. CO.

A. United States District Court for the Western District of Tennessee

Parker’s ERISA claim against MetLife was that its refusal to pay her disability benefits was a violation of the terms of the plan\(^ {344}\) inasmuch as her disability was physical, not mental, in nature. Applying a deferential standard of review to the insurer’s decision to terminate benefits, the district court determined that MetLife’s decision that Parker’s disability was at least partially mental or nervous, and its consequent denial of benefits beyond the twenty-four month period, was not unreasonable.\(^ {345}\)

\(^{342}\)EEOC: INTERIM POLICY GUIDANCE ON ADA AND HEALTH INSURANCE (JUNE 8, 1993); AMERICANS WITH DISABILITIES ACT MANUAL (BNA) 70:1051 No. 18, FAIR EMPL. PRAC. MANUAL (BNA) 405: 7115.

\(^{343}\)Because this second issue, involving "fair discrimination" and subterfuge, is also related to Title III claims, further discussion is found supra Part VII.

\(^{344}\)29 U.S.C. § 1132(a)(1)(B) (1974) allows a plan participant or beneficiary to bring a civil action to enforce rights under the plan or to clarify the right to receive future benefits.

\(^{345}\)Parker, 875 F. Supp. 1321. Although the district court was responding to MetLife’s Motion for Summary Judgment, a deferential standard of review was said to be proper for the following reasons. Under ERISA, a claim that benefits were improperly denied is "reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." Id. at 1328 (citation omitted). If discretionary authority is retained,
The district court recognized an ERISA decision by the United States Court of Appeals for the Eighth Circuit, *Brewer v. Lincoln Nat'l Life Ins. Co.*, 346 in which the claimant argued that the biological causes of her affective mood disorder removed it from the definition of mental illness and placed it within the definition of physical illness. However, The Eighth Circuit declined to consider the possibility of biological causes. Instead, it emphasized that the terms of an ERISA plan should be given their ordinary meanings. Even though laypersons might understand that some mental illnesses are biological in origin, these laypersons would classify a disease by its symptoms, not by its origins. Since laypersons would characterize the claimant’s symptoms as a mental illness, the court would also do so for purposes of an ERISA claim.347

The *Parker* district court similarly concluded that defendant MetLife’s Motion for Summary Judgment should be granted.

Based on a thorough review of the record that was before MetLife . . . MetLife’s decision was reasonable in light of . . . the plan[’s] provisions . . . The provision says nothing about what the origin or cause of the mental disorder must be, and under *Brewer*, MetLife properly determined that regardless of the origins of plaintiff’s depression that plaintiff should be reimbursed under the nervous/mental illness clause of the policy.348

Defendant Schering-Plough was also successful in its Motion for Summary Judgment on the ERISA claim. The district court recognized that under some circumstances an employer may be a proper party under the ERISA section relied upon by *Parker*. Under the particular circumstances of this case, however, whether Schering-Plough was a proper defendant was found immaterial because the administration of the plan did not violate ERISA.

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then a deferential standard of review is appropriate. In the benefits plan in this case, MetLife had such discretionary authority and was consequently entitled to a deferential standard of review.

Under this standard, "an ERISA benefit plan administrator's decisions on eligibility for benefits are not arbitrary and capricious if they are rational in light of the plan's provisions." *Id.* at 1330 (citation omitted). While the possible existence of a conflict of interest must be taken into account as a factor in determining whether discretion has been abused, a conflict of interest does not change the arbitrary and capricious standard of review. *Id.*

346921 F.2d 150 (8th Cir. 1990).

347 *Parker*, 875 F. Supp. at 1331. The district court concluded, "Thus, in determining whether the condition could be classified as a 'mental illness' under the policy, the *Brewer* court did not focus on the condition's etiology." *Id.*

348 *Id.* at 1332.

349 *Parker’s* ERISA claim against her employer was a wrongful denial of benefits claim under § 502(a)(1)(B) of ERISA.
B. United States Court of Appeals for the Sixth Circuit

The Sixth Circuit three-judge panel affirmed the district court's conclusion that Parker had no ERISA claim because the benefit plan retained discretionary authority which was not exercised arbitrarily or capriciously in determining that Parker's illness should be classified as nervous/mental rather than physical. The panel added, however, that "[i]f the standard of review were de novo, perhaps there would be a genuine issue of material fact as to whether chemical imbalances which lead to depression are 'physical' or 'mental' disorders."350

The ERISA claim was not presented to the en banc Sixth Circuit.

VII. Title III of the Americans with Disabilities Act

A. Language of the Statute

Title III of the ADA prohibits public accommodations from discriminating against persons with disabilities. A person who as a benefit of employment receives long-term disability benefits for mental disabilities that are inferior to benefits for physical disabilities may challenge the disparity under Title III of the ADA351 by suing the insurer. There are two major issues in Title III litigation in such cases. The first is a threshold issue: whether the insurer, which has contracted with an employer to offer disability coverage to the employees, is a public accommodation. The second issue is whether the disparity between physical and mental benefits comes within the safe harbor or subterfuge provisions of Title V of the ADA.352

All courts begin the analysis of the threshold issue with consideration of the language of the statute. Title III is governed by a general rule:

No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation.353

The statute goes to some lengths to elaborate what constitutes discriminatory conduct under the general rule. For example, the statement of

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35099 F.3d 181, 185.
352Title V, 42 U.S.C. §§ 12201-12213 (1990), addresses diverse miscellaneous matters, including provisions for attorneys fees, requirements that various federal agencies develop technical assistance plans to assist covered entities to comply with the Act, and exclusions of certain conditions and disorders (such as sexual behavior disorders, compulsive gambling, and illegal use of drugs) from the definition of disability. Title V is implicated in Title III cases of the type discussed in this article because it includes a section related to insurance.
the general rule is immediately followed with activities that come within the
general prohibition, including denial of participation in a benefit, participation
in an unequal benefit, or provision of a separate benefit. Specific examples
of discrimination under the general rule are then set forth such as imposition
of eligibility criteria that screens out individuals from equally enjoying
services, privileges, or advantages.

The threshold issue arises over the meaning of the phrase place of public
accommodation as it appears in the general rule. Does the phrase mean that a
disabled person merely must be provided non-discriminatory access to the

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354 It shall be discriminatory to subject an individual or class of individuals
on the basis of a disability or disabilities of such individual or class,
directly, or through contractual, licensing, or other arrangements,
to a denial of the opportunity of the individual or class to partici-
pate in or benefit from the goods, services, facilities, privileges,
advantages, or accommodations of an entity.

It shall be discriminatory to afford an individual . . . on the basis of
a disability . . . of such individual . . . directly, or through contractual,
licensing, or other arrangements with the opportunity to participate
in or benefit from a good, service, facility, privilege, advantage, or
accommodation that is not equal to that afforded to other individuals.

It shall be discriminatory to provide an individual . . . on the basis
of a disability, . . . with a good, service, facility, privilege, advan-
tage, or accommodation that is different or separate from that pro-
vided to other individuals, unless such action is necessary to provide
the individual or class of individuals with a good, service, facility,
privilege, advantage, or accommodation, or other opportunity that
is as effective as that provided to others.

For purposes of clauses (i) through (iii) of this subparagraph, the
term "individual or class of individuals" refers to the clients or cus-
tomers of the covered public accommodation that enters into the
contractual, licensing, or other arrangement.

It is made clear that the general rule is to be construed to apply to administrative
methods:
An individual or entity shall not, directly or through contractual
or other arrangements, utilize standards or criteria or methods of
administration—
(i) that have the effect of discriminating on the basis of disability;
or
(ii) that perpetuate the discrimination of others who are subject
to common administrative control.
42 U.S.C. § 12182(b)(D).

355 Discrimination includes:
the imposition or application of eligibility criteria that screen out or
tend to screen out an individual with a disability . . . from fully and
equally enjoying any goods, services, facilities, privileges, advantages,
or accommodations . . .
places—the physical structures—in which goods and services are offered to the public? Or does the general rule mean that disabled persons must be provided non-discriminatory access to the goods and services that are offered to non-disabled members of the public, not only when they present themselves at the physical place of business, but also when they access the goods and services in some other way (for example, by telephone or as a result of contract obtained as a benefit of employment)? Courts have held both ways, using the definitional sections of Title III to demonstrate the correctness of their decisions.

Title III defines public accommodation by providing a non-exclusive list of examples. The listed examples frequently make use of the word "place" (as in place of lodging, place of exhibition, place of public gathering, or place of education), especially to extend the examples of the subsection to similar entities. The term "establishment" is also used (as in rental establishment or social service establishment). The use of these terms seems to support the view that the term public accommodation is limited to physical structures. But consider subsection (F):

The following private entities are considered public accommodations for purposes of this subchapter, if the operations of such entities affect commerce—

(F) a laundromat, dry-cleaner, bank, barber shop, beauty shop, travel service, shoe repair service, funeral parlor, gas station, office of an accountant or lawyer, pharmacy, insurance office, professional office of a health care provider, hospital, or other service establishment.

Unlike other sections of the statute, subsection (F) mixes entities which principally might present a disabled person with problems of physical access (in order to wash clothes one must be able to get into and maneuver about the laundromat) with entities which principally might present a disabled person with problems of access to services (the significant aspect of a travel service is not access to the physical office, it is planning and arranging the vacation). While this distinction cannot be taken too far, it is useful in understanding how courts read this subsection.

What is the plain meaning of the statute? A majority of the courts which have addressed the issue have held that the plain meaning requires an expansive reading of the statute. However, other courts have believed that the plain meaning of the statute requires the restriction of Title III to access to physical structures.

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357 For example, the statute lists as public accommodations: "a park, zoo, amusement park, or other place of recreation" 42 U.S.C. § 12181(7)(1) (emphasis added). The word place is presumed used to extend the example to such things as playgrounds, swimming pools, or golf courses.


structures. The plain meaning is ambiguous. This ambiguity has led to conflict among the federal circuits with respect to the threshold issue which is the subject of this article.

B. Cases Related to Parker v. Metropolitan Life Ins. Co.

The conflict in the circuits over the Title III threshold issue is best understood by first having familiarity with related Title III holdings. The following sections examine those related cases.

1. Cases Limiting Title III to Physical Structures

In Ford v. Schering-Plough Corp., the court was presented with Ford's claim that defendants Schering-Plough, the employer, and Metropolitan Life Insurance Company (MetLife), the carrier, violated Title III of the ADA by providing plaintiff with a policy containing inferior long-term mental disability benefits. The court determined that the "plain meaning of Title III is that a public accommodation is a place." Thus, neither defendant could be pursued under Title III as neither was a place of public accommodation. Since Ford received her disability benefits via her employment at Schering, she had no nexus to Metlife's 'insurance office' and thus was not discriminated against in connection with a public accommodation.

The court recognized that its holding conflicted with the First Circuit's decision in Carparts, but criticized that opinion for its failure to interpret the Act through application of the doctrine of noscitur a sociis. Rather, this court determined that "we do not find the term 'public accommodation' or the terms in 42 U.S.C. § 12181(7) to refer to non-physical access or even to be ambiguous as to their meaning." As a result of this reasoning, plaintiff's claim under Title III was defeated. This, combined with the determination that there was no Title I discrimination, left a disabled person with no ADA protection despite the obvious disparate and inferior treatment provided for persons with mental disabilities.

Pappas v. Bethesda Hospital Ass'n, was decided by the United States District Court for the Southern District of Ohio. Pappas sued her employer, Bethesda

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360 145 F.3d 601 (3d Cir. 1998).

361 Id. at 612.

362 Id. at 612-13, relying on Title II of the Civil Rights Act, Department of Justice regulations, and the en banc majority opinion in Parker.

363 Carparts, 37 F.3d 12. For further discussion see infra notes 377-78 and accompanying text.

364 Id. at 614.

365 Id.

366 See supra notes 280-85 and accompanying text.

Hospital, which offered a health insurance plan, and Benefit Services Agency, Inc. (BSAI), which administered the plan, because members of her family were denied health insurance coverage due to their pre-existing medical conditions. She claimed that both defendants were in violation of Titles I and III of the ADA inasmuch as both were covered entities under Title I and public accommodations under Title III.

Pappas’ Title III claim was premised on the argument that the sale of insurance contracts was within the plain language of Title III, which includes in the list of public accommodations both insurance offices and hospitals. She also asserted that the sale was within Department of Justice regulations which state that insurance contracts discriminating on the basis of disability are prohibited by Title III.

In opposition, both defendants claimed that Title III was limited to physical structures. The district court agreed because Congress “unambiguously expressed its intent with respect to the applicability of Title III as it relates to the physical use of a place of public accommodation.” Although Bethesda Hospital was a physical place within the definition of public accommodation, plaintiff was not denied access to its facility. Obviously, she had access when she went to work. With respect to BSAI, the court reasoned that “because plaintiff did not enter its physical structure, it is not a public accommodation.” Further, the district court found the plaintiff’s claim did not involve an inability “to make physical use of the services of a place of public accommodation. . . . [Therefore] there is no nexus whatsoever between the alleged discrimination and any public accommodation.” This nexus language has proven to be attractive to other courts.

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368 Plaintiff’s son was a paraplegic and her husband was being treated for hypertension and hyperlipidemia. Id. at 617.

369 Plaintiff also asserted civil rights violations under 42 U.S.C § 1985(3). Id. at 617-18.

370 The court concluded that plaintiff did not state a Title I claim against BSAI. It reached this conclusion by relying in part, on the district court decision in Carparts, 826 F. Supp. 583, (D.N.H. 1993), rev’d 37 F.3d 12 (1st Cir. 1994). Because plaintiff did not allege that BSAI was her employer, or that Bethesda had delegated any responsibilities regarding employee benefits to BSAI now that BSAI was controlled by Bethesda in a way that could create an agency relationship, plaintiff did not state facts sufficient to state a claim under Title I. Thus the court held that “the administrator of employee benefits for a statutory employer under the ADA is not an agent of that employer and therefore may not be held liable for benefits that discriminate based on disability.” Id. at 619.


373 Pappas, 861 F. Supp. at 620.

374 Id. at 619.

375 Id. at 620.
2. Cases Applying Title III More Expansively

a. Circuit Courts

Carparts, a First Circuit opinion, is the principal case for an expansive reading of the phrase "place of public accommodation." In its analysis of Title III, the court began at the familiar starting point of examining the language of the statute. In the statutory definition of a public accommodation the court found an illustrative list of private entities that are considered to be public accommodations if they affect commerce. Included in the list are such entities as a travel service, a shoe repair service, the office of an accountant or lawyer, an insurance office, and a professional office of a health care provider. The First Circuit held "[t]he plain meaning of the terms do not require 'public accommodations' to have physical structures for persons to enter." The plain meaning understood by the court came from the variety of listed entities that can be classified as "service establishments" which can provide business services by telephone or correspondence without requiring the customer or client to enter a physical structure. "It would be irrational to conclude that persons who enter an office to purchase services are protected by the ADA, but persons who purchase the same services over the telephone or by mail are not. Congress could not have intended such an absurd result." The court further explained that even if the meaning of public accommodation is not plain, "it is at worst, ambiguous," but the ambiguity is easily resolved by consultation of agency regulations and public policy concerns demonstrated in the legislative history. The court recognized that the statutorily stated purposes of the ADA include invocation of congressional authority to eliminate discrimination against people with disabilities in their day to day lives by bringing them into the social mainstream, and referred to a Senate Report that showed the intent to provide equal access to goods and services to persons with disabilities. Specifically, with respect to the

376 Plaintiff's Title VII claim was also rejected by the court which held that the Civil Rights Act would not be so broadly interpreted as to include a claim that more readily fits under the ADA. Id. at 622.

377 Carparts, 37 F.3d 12.

378 See supra notes 269-79 and accompanying text for discussion of Carparts related to Title I.

379 Carparts, 37 F.3d at 19, citing 42 U.S.C. § 12181(7)(F).

380 Id.

381 Id. at 19. This use of the term may be unique to the court.

382 Id.

383 Id.

384 Carparts, 37 F.3d at 19, citing 42 U.S.C. § 12101(b).

purposes of Title III, the court found that "Congress intended that people with disabilities have equal access to the array of goods and services offered by private establishments and made available to those who do not have disabilities."386

While the First Circuit understood the plain language of Title III to extend the protections of the Act beyond physical structures, the court acknowledged that there is less clarity in sections of the statute guaranteeing a person with a disability the opportunity "to participate in or benefit from the goods, services, facilities, privileges, advantages, or accommodations of an entity."387 These sections do not clearly state whether the ADA intends to regulate the contents of the products and services offered or only to provide access to existing products and services. The safe harbor provision is also identified as containing an ambiguity: Is the provision merely intended to assure that Title III is not applied to direct the content of insurance plans, or is the provision intended to clarify language contained in Titles I, II and III applying to insurance?388

There is additional, though less persuasive, authority that Title III should not be construed to be limited to physical structure in an important Seventh Circuit case, Equal Employment Opportunity Commission v. CNA Insurance Companies.389 This case was decided on Title I grounds: the plaintiff was not a qualified employee with a disability because her disability made it impossible for her to continue to work.390 CNA has become important for that proposition. It is most interesting, however, that the court emphasized that its ruling was limited to Title I claims, adding that "different considerations come into play when discrimination based on disability is alleged for programs or services addressed by other subsections of the Act."391 Perhaps wisely, the court did not elaborate. The court's remark is notable for its unequivocal quality. The court did not say that there "may" be different considerations, or that other subsections of the Act "might" generate a different result. Instead, the court seemed to recognize two very important principles. The first is that the other subsections of the ADA (Title II, which applies to public services, and Title III, which applies to public accommodations) provide protection to disabled persons that differs in scope from that provided by Title I. The second is that the other subsections apply to programs or services. Apparently, when the Seventh Circuit read Title III in 1996, it did not understand it to be limited to physical structures.

38637 F.3d at 19, citing S. REP. No. 116, at 58 (1989).
387Id., citing 42 U.S.C § 12182(b)(1)(A)(i).
388Id. at 20, citing S. REP. No. 116, at 84 (1989).
38996 F.3d 1039 (7th Cir. 1996).
390See supra notes 247-56 and accompanying text for discussion related to Title I.
391EEOC v. CNA, 96 F.3d at 1045.
b. District Courts

Other courts have also reached the conclusion that Title III is not limited to physical structures. In *Baker v. Hartford Life Insurance Co.*, the plaintiff was a minor with a history of seizure disorder which had been controlled by medication for several years. In 1993, the defendant made a telephone solicitation to plaintiff's father, offering him the opportunity to apply for major medical insurance. Plaintiff's father made the application. For the next year and nine months he endeavored to get an authoritative answer as to whether his application had been granted. Eventually, defendant's agents said that the application was denied because plaintiff's medical history presented a greater risk than allowed by the company's guidelines.

Plaintiff filed suit under Titles III and V of the ADA alleging (a) denial of major medical insurance coverage on the basis of his disability denied him full and equal enjoyment of defendant's services; (b) denial of insurance denied him the opportunity to benefit from the defendant's services; (c) denial of benefits was based on disability not on state law; (d) defendant's failure to conform with its own procedures for appeal denied a service to an individual with a disability that it provided to non-disabled individuals; and (e) the grounds given for denying coverage—greater risk and reference to vague guidelines—was an intentional subterfuge of ADA policies.

Defendant's responses to these claims were, first, that it was not a public accommodation under Title III, and second, that Title V provides insurers an exemption from ADA liability. Again, the meaning of public accommodation was contested with defendant claiming the scope of the term is limited to physical structures and plaintiff claiming the term encompasses companies that solicit business by mail or telephone.

The court easily found the plaintiff to be a disabled person entitled to the protections of the ADA. The court as easily found that "[t]he place from which defendant's telephone communication with plaintiff's father took place was an insurance office, so it was a public accommodation." Still considering the language of the statute, the court elaborated:

The statute's use of the word "place" does imply a physical location but, contrary to defendant's argument, the ADA does not require a

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393 The court sets out in detail plaintiff's father's efforts to provide requested documentation, accurately determine the defendant's response to his application and conform to the reconsideration process established by the defendant. *Id.* at *1-2.
394 *Id.* at *2.
395 *Id.*
396 *Id.*
398 *Id.*
plaintiff to be physically present at the place of public accommodation to be entitled to non-discriminatory treatment. What the statute forbids is discrimination against an individual in the full and equal enjoyment of the goods, services, and so forth, of a place of public accommodation, which discrimination can occur... when a plaintiff is not physically present at the place of public accommodation and only has contact with that place through his father by telephone and correspondence.\textsuperscript{399}

The district court further held that the safe harbor provision is not a blanket exemption of insurance companies from the requirements of the ADA. Whether coverage was denied to plaintiff on the permissible basis of underwriting or classifying risks, or whether actuarial reasons were given merely as a subterfuge to deny plaintiff coverage on the basis of disability,\textsuperscript{400} was said to be a question of fact to be established at trial.

In \textit{Sharrow v. Bailey},\textsuperscript{401} the plaintiff, who was HIV positive, sued a doctor who delayed surgery on the plaintiff for one day because the doctor was not provided with requested protective equipment. Plaintiff's complaint contained ADA, Rehabilitation Act, and intentional and negligent infliction of mental distress claims.

The doctor argued he was outside the scope of Title III of the ADA because he treated and operated on the plaintiff not at his private offices, but at a hospital at which he was neither an employee nor in a position of authority.\textsuperscript{402} The district court cited cases from other jurisdictions which held that it is not necessary for a plaintiff to show that a doctor "holds a position of authority with the hospital to establish that he owns or operates a public accommodation."\textsuperscript{403} It was not significant that the defendant never examined the plaintiff at his private office.\textsuperscript{404} Instead, the district court emphasized the remedial intent of the ADA and impliedly extended the scope of Title III beyond mere physical structures.

\textit{[T]he obvious intent [of Title III] is to preclude the denial of services available to the public generally by reason of an individual's disability. To superimpose on the statute a requirement that the plaintiff must present himself or herself at the defendant's place of business and there

\textsuperscript{399}Id. at *3.
\textsuperscript{400}Id. at *3-4.
\textsuperscript{402}Id. at 192.
\textsuperscript{403}Id.
\textsuperscript{404}Id.
be denied service or receive unequal service would be illogical and contrary to the underlying intent of the Act.\textsuperscript{405}

In \textit{Kotev v. First Colony Life Insurance Co.},\textsuperscript{406} the plaintiff attempted to privately purchase life insurance from the defendant. His application was denied on the ground that his wife was HIV-positive, which placed him in a high-risk category.\textsuperscript{407} Plaintiff filed suit against the insurance company alleging that the denial was based solely on his relationship with his wife without actual assessment of the nature and degree of risk the relationship actually posed to him.\textsuperscript{408} Plaintiff's complaint stated claims under Title III of the ADA, under a state civil rights act, state tax and insurance codes, and for intentional and negligent infliction of emotional distress.\textsuperscript{409}

Defendant argued that Title III was limited to circumstances of denial of access to physical structures and that consequently plaintiff's Title III claim should be dismissed because the plaintiff "was not denied physical access to . . . any of its facilities by reason of any purported disability."\textsuperscript{410} The district court disagreed and held that the plain language of Title III extends the Act's protection beyond physical structures.\textsuperscript{411} However, because the court recognized that other courts had read the plain language of the Act to restrict Title III to physical structures,\textsuperscript{412} the court explained its rationale.

The district court first examined the statute and found "Title III's plain language does not refer to access to physical structures."\textsuperscript{413} To read the statute that narrowly would be to contradict the broad purpose of the ADA, which is to provide a national mandate to eliminate discrimination against people with

\textsuperscript{405}Id. The court relied in part on the holding of \textit{Carparts}, elaborating on the idea of ADA applicability to telephone communication: Here the result is no different than a situation in which a patient telephones a dentist or physician, informs him of his disability, . . . and is denied treatment on the basis of that disability. The fact that the denial did not take place on defendant's premises does not mean that no violation occurred and no cause of action exists. \textit{Id.} at 192.


\textsuperscript{407}Id. at 1317.

\textsuperscript{408}Id.

\textsuperscript{409}Kotev's state civil rights, tax and insurance code claims survived a motion to dismiss. \textit{Id.} at 1320. His intentional and negligent infliction of mental distress claims were dismissed for failure to make proper allegations of relationships sufficient to give rise to the claims, but he was granted opportunity to amend his complaint on these matters. \textit{Id.} at 1324.

\textsuperscript{410}Id. at 1320.

\textsuperscript{411}Kotev, 927 F. Supp. at 1321.

\textsuperscript{412}The court cited \textit{Pappas}, 861 F. Supp. 616 (S.D. Ohio 1994) and the district court opinion in \textit{Parker}. Both cases were decided by district courts in the Sixth Circuit.

\textsuperscript{413}Kotev, 927 F. Supp. at 1321.
disabilities by addressing the "major areas of discrimination faced day-to-day by people with disabilities." The court pointed out that the ADA protects not only people who are disabled, but also people who are able-bodied but who are related to, or associate with, those who are disabled. The court reasoned that if Title III is limited to providing access to physical structures, then the able-bodied would only have a Title III claim "if the public accommodation took affirmative steps to block such person physical access. The Court does not believe that Congress intended such an anomalous result." The definition of discrimination also argues for the more expansive application of Title III. Discrimination includes the use of criteria that prevent the enjoyment of goods, services and facilities and the failure to make accommodations in policies and practices.

Furthermore, the court noted the safe harbor and subterfuge provisions of the Act and stated the defendant "has not explained why insurers would need this 'safe harbor' provision under Title III if insurers could never be liable under Title III for conduct such as the discriminatory denial of insurance coverage." Finally, the court considered Department of Justice Regulations and legislative history and concluded, as has every court that has considered this authority, that Title III applies to insurance policies.

C. Parker v. Metropolitan Life Insurance Co.

1. United States District Court for the Western District of Tennessee

Title III of the ADA provides that "[n]o individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or

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414 Id.
415 Id.
417 Id. at 1322.
418 Kotev, 927 F. Supp. at 1322.
419 Id. This problem arises because the referenced section, 42 U.S.C. § 12201(c), specifically states that it is relevant to Titles I and III. In a related ruling, the court rejected the defendant's contention that the safe harbor provision bars a Title III claim altogether, and declined to rule whether the defendant's action in this case is protected by the safe harbor provision. Id. at 1323.
operates a place of public accommodation." The Act elaborates that "[i]t shall be discriminatory to afford an individual . . . on the basis of a disability . . . with the opportunity to participate in or benefit from a good . . . that is not equal to that afforded to other individuals." Furthermore, "[i]t shall be discriminatory to provide an individual . . . on the basis of a disability . . . with a good . . . that is different or separate from that provided to other individuals . . ." 423

In Parker plaintiff argued that the plain language of these sections demonstrated that defendants, Schering-Plough and Metropolitan Life, discriminated against her when they provided less long-term disability benefits for mental disabilities than for physical disabilities. The district court rejected the argument quoting the reasoning of Pappas 424 that the ordinary common meaning of the words in the statute make it clear that "its scope is limited to discrimination in the provisions of goods, services, facilities, privileges, advantages or accommodations based on a disabled person's physical ability to make use of those goods, services, etc." 425

The court said Parker failed to state a claim against MetLife because she did not allege that she was denied use of the goods and services at a place of public accommodation. Though MetLife did admit having public offices that might be within the scope of Title III, Parker was not denied access to those offices. Rather, she received disability insurance as a benefit of employment. After consulting the ADA's legislative history the court also dismissed Parker's Title III claim against her employer, Schering-Plough. The court held that Title I, not Title III, governs the employment relationship. 426

In short, Parker's Title III claim against her employer failed because Title III does not apply to employers, and her Title III claim against MetLife failed because Title III only requires access to physical structures.

2. United States Court of Appeals for the Sixth Circuit—Three-Judge Panel

Parker appealed to the United States Court of Appeals for the Sixth Circuit. 427 The developing importance of this case is evident from the fact that amicus briefs were filed by several AIDS and mental health interest groups, and the EEOC. 428 The Sixth Circuit three-judge panel 429 reversed the district

425 Parker, 875 F. Supp. 1321 at 1327 (citing Pappas).
426 Id. at 1327-28.
427 Parker, 99 F.3d 181 (6th Cir. 1996).
428 The EEOC is charged with the duty to enforce the ADA. See supra note 234.
429 The three-judge panel consisted of Circuit Judges Merritt and Milburn and Judge O'Malley, United States District Court Judge for the Northern District of Ohio, sitting
court's Title III decision by recognizing Parker's standing to bring the claim.430 This court remanded the case to allow Parker to prove that the physical/mental distinction is, as a substantive matter, discrimination under the ADA.431

In deciding whether it is a violation of Title III to provide long-term mental disability benefits that are less than physical disability benefits, the three-judge panel first considered whether the ADA "prohibits discrimination in the contents of the goods and services offered at places of public accommodation, rather than just discrimination in terms of physical access to places of public accommodation."432 Beginning from the principle that statutory language must be interpreted according to its common or ordinary meaning, the three-judge panel examined the relevant language of the "general rule" of Title III to determine whether the ADA prohibits discrimination beyond access to physical places. The court focused on the same language as had the district court.433

The panel found that giving common and ordinary meaning to the terms of the statute, Parker could establish all the elements for a Title III claim: Parker was disabled; MetLife434 was a public accommodation specifically included in the statute; provision of insurance coverage is within the common and ordinary meaning of "service"; insurance products are included within the common meaning of "goods"; and the good or service that Parker received was different from what other individuals received.435 Moreover, the panel found that to interpret the Act to be limited merely to physical structures would render parts of the statute superfluous, a result that would be in contravention to Supreme Court direction.436 The panel added that even if the statutory language were not so clear, its interpretation was consistent with the principle that remedial

by designation.

43099 F.3d at 184. Parker's Title III claim was that defendants denied her the opportunity to have access to a good or service on the basis of her disability. The panel affirmed the district court's decisions on Parker's Title I and ERISA claims. Id. at 183.

431Id. at 184.

432Id. at 187.

433See supra notes 421-26 and accompanying text.

434Whether Parker's employer, Schering-Plough, was a proper defendant under Title III was not determined by the panel. The issue is in doubt since Title I applies to terms and conditions of employment while Title III applies to public accommodations, goods and services.

435Parker, 99 F.3d at 188.

436Id. (citing Burns v. United States, 501 U.S. 129, 145 (1991)). It appears that if defendants and the district court were correct, the general rule of Title III could be more clearly written to say: 'No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of access to any place of public accommodation.' In essence the court recognized that proper wording would have made it unnecessary to mention anything at all about goods, services, facilities, or advantages.
statutes should be interpreted broadly, in a matter consistent with their stated goals.\textsuperscript{437}

The three-judge panel compared several cases which reached the same conclusion, particularly approving of language in \textit{Carparts},\textsuperscript{438} which held that Title III is not limited to physical structures.

Many goods and services are sold over the telephone or by mail with customers never physically entering the premises of a commercial entity to purchase the goods or services. To exclude this broad category of businesses from the reach of Title III and limit the application of Title III to physical structures which a person must enter to obtain goods and services would run afoul of the purposes of the [Americans With Disabilities Act] and would severely frustrate Congress's intent that individuals with disabilities fully enjoy the goods, services, privileges and advantages, available indiscriminately to other members of the general public.\textsuperscript{439}

The panel found the Rehabilitation Act cases relied on by the district court to be unpersuasive. Such reliance was misplaced, in part, because the ADA was intended to redress the inadequacy of such laws as the Rehabilitation Act which had failed to alleviate the discrimination experienced by disabled persons. To limit the scope of the ADA to the terms of the Rehabilitation Act would be to frustrate the very purpose of the ADA. The conclusion that protection of Title III extends beyond mere physical structures to goods and services answered the threshold question affirmatively and allowed the panel to proceed to the substantive second issue which was whether insurance products are exempted from Title III by the safe harbor provisions of Title V to the extent that they are drafted in conformity with state law.\textsuperscript{440}

\textsuperscript{437}\textit{Id.}

\textsuperscript{438}\textit{37 F.3d 12. The panel impliedly criticized the district court which "declined to follow [Carparts] without discussion." Parker, 99 F.3d at 188-89.}

\textsuperscript{439}Parker, 99 F.3d at 189-90 (citing \textit{Carparts}, 37 F.3d at 20).

\textsuperscript{440}Title V of the ADA, 41 U.S.C. §§ 12201-12213 (1990), contains the safe harbor and subterfuge provisions:

\textit{(c) Insurance}

Subchapters I through III of this chapter and Title IV of this Act shall not be construed to prohibit or restrict:

(1) an insurer . . . from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or

(2) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that are based on underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law; or

(3) a person or organization covered by this chapter from establishing, sponsoring, observing or administering the terms of a bona fide benefit plan that is not subject to State laws
The panel found the safe harbor provision to be "totally ambiguous on its face."\textsuperscript{441} Citing United States Supreme Court authority to do so, the panel consulted legislative history for guidance in interpreting the provision.\textsuperscript{442} The legislative history enabled the panel to find that the Congress did not intend to completely insulate the insurance industry from the ADA. Instead, it found that "insurance practices are protected by the 'safe harbor' provision, but only to the extent that they are consistent with 'sound actuarial principles,' 'actual reasonably anticipated experience,' and 'bona fide risk classification.'"\textsuperscript{443} The panel added that

[i]t seems unlikely that Congress would leave the insurance industry virtually untouched by a statute that is designed to address the major areas of discrimination faced day-to-day by people with disabilities. There could hardly be a "good" or a "service" more central to the day-to-day life of a seriously disabled person than insurance—for it is often insurance coverage that will determine a disabled person's ability to prevent the disability from limiting his or her participation in society.\textsuperscript{444}

Although it recognized that agency interpretations of statutes are not binding on the courts,\textsuperscript{445} the panel found it informative that the EEOC considers insurance products to be covered by the Act.\textsuperscript{446}

Concluding there is no complete exemption, the panel's analysis proceeded to the last issue which was whether the ADA offers protection to insurance products in two circumstances: when the insurance product contains terms which are disparate but which are not intended as a subterfuge to avoid the purposes of the ADA, and when the insurance product was adopted before the ADA was enacted.

\textsuperscript{441}\textit{Parker}, 99 F.3d at 190. The Court complained that the drafters of the statute made it "purposely vague" in order to reach political compromise among conflicting interest groups. "One provision [of the statute] attempts to appease the insurance industry; the other provisions attempt to help the large group of disabled people. In doing so, Congress has again left this Court in a position to give meaning to conflicting statutory language designed as a political compromise." \textit{Id.}

\textsuperscript{442}\textit{Id.} (citing \textit{Blum v. Stenson}, 465 U.S. 886, 896 (1984)).

\textsuperscript{443}\textit{Parker}, 99 F.3d at 191.

\textsuperscript{444}\textit{Id.} at 192-93 (citations omitted).

\textsuperscript{445}\textit{Id.} at 193.

\textsuperscript{446}\textit{Id.} (citing Department of Justice, \textit{AMERICANS WITH DISABILITIES ACT TECHNICAL ASSISTANCE MANUAL} § III-3.11000).
Again relying on legislative history, the three-judge panel found that the safe harbor section was not intended to exempt plans adopted before the ADA was enacted. It, therefore, rejected the holding of *Modderno v. King*, a Rehabilitation Act decision which held to the contrary. The panel concluded that "the subterfuge language would apply to the coverage limitation imposed on the Plaintiff in this case if it qualifies as an attempt [to] evade the purposes of the Act, regardless of when it was first instituted." The question of whether the disparity between the mental illness benefits and physical illness benefits at issue came within the safe harbor provision, or whether it constituted a violation of Title III would have to be determined on remand. A final result could not be reached because the case was disposed of by the district court on summary judgment which provided no opportunity to develop a record showing the reasons for the disparity of benefits.

At the end of the panel's opinion, two points are made, almost casually, that become significant at the next level of review. The first point raises the question of whether long-term disability benefits are in some way different from health insurance benefits and should therefore be treated differently under the ADA. The defendants had argued that EEOC regulations sanction a lower level of benefits for treatment of mental illness than physical illness in health insurance benefits. The panel reports that the plaintiff's response to this argument was that long-term disability, unlike health insurance, is a 'wage replacement' benefit, not medical coverage. Thus . . . the differentiation between mental and physical ailments may be justified in the health insurance context, but there is no similar basis for the distinction in the long-term disability realm because of the nature of the coverage.

The second casually mentioned point comes from an alternative argument offered by defendants to the effect that the ADA prohibits discrimination against the disabled as compared to the non-disabled, but does not prohibit...
differentiation between groups of disabled persons.\textsuperscript{452} Again, the panel offered no comment. Yet this argument was found to be significant at the next level of review.

3. United States Court of Appeals for the Sixth Circuit—En Banc Majority

The defendants petitioned for a rehearing \textit{en banc} of the three-judge panel's decision on Parker's Title III claim.\textsuperscript{453} Rehearing was granted\textsuperscript{454} and the case was reargued before thirteen judges. Once again the importance of the case was underscored by the filing of amicus briefs. Representatives of the insurance industry offered additional assistance to the court.\textsuperscript{455} Upon rehearing, eight circuit court judges joined an opinion reversing the three-judge panel's decision on Parker's Title III claim and affirming the district court's decision. Five judges dissented in two separate opinions.

\textit{a. Place of Public Accommodation}

The \textit{en banc} majority started its analysis at the same place the three-judge panel had begun: consideration of the statutory language to determine whether Title III only prohibits discrimination in access to physical structures or whether it also prohibits discrimination in the contents of goods and services. The \textit{en banc} majority examined the ADA's general rule which prohibits discriminatory treatment of a person with a disability by a place of public accommodation,\textsuperscript{456} which lists the private entities that are considered public accommodations,\textsuperscript{457} and which specifically prohibits a place of public accommodation from providing unequal or separate benefits.\textsuperscript{458} The majority concluded that while an insurance office is a place of public accommodation, Parker did not seek the goods and services of an insurance office. Rather, Parker accessed a benefit plan provided by her private employer and

\textsuperscript{452}Id. at 194.

\textsuperscript{453}Rehearing on the ERISA claim was not sought by either party. Parker v. Metropolitan Life Ins. Co., 121 F.3d 1006, 1009, n.1 (6th Cir. 1997)(en banc). Plaintiff did not seek rehearing of the district court's decision on her Title I claim. \textit{Id.} at n.2.

\textsuperscript{454}The Order states, "A majority of the judges in regular active service have voted for rehearing of this case en banc." \textit{Parker}, 107 F.3d 359, at 359. The effect of the Order was to stay the mandate and restore the case on the docket as a pending appeal. Supplemental briefs were ordered from all parties.

\textsuperscript{455}\textit{Parker}, 121 F.3d at 1007-08.


\textsuperscript{457}42 U.S.C. § 12181(7), which states: "The following private entities are considered public accommodations for purposes of this subchapter, if the operations of such entities affect commerce—... (F) ... insurance office..."

\textsuperscript{458}E.g., 42 U.S.C. § 12182(b)(1)(A)(i)-(iv). For text \textit{see supra} note 354.
issued by MetLife. A benefit plan offered by an employer is not a good offered by a place of public accommodation. As is evident by § 12187(7), a public accommodation is a physical place.  

In support of the conclusion that the term public accommodation refers only to a physical place, the majority relied on the authority of a case decided by the Sixth Circuit, Stoutenborough v. National Football League, Inc.\(^\text{460}\) In Stoutenborough, the plaintiffs were hearing-impaired individuals who complained that the NFL's blackout rule discriminated against them because when telecasts were blacked out the plaintiffs had no other means to access the games. The court in Stoutenborough found the plain language of the ADA showed that the NFL did not fall within any of the categories of public accommodation set forth in Title III.\(^\text{461}\) That court also found that Department of Justice regulations which further define the terms place and facility\(^\text{462}\) limit Title III to physical structures.

The majority found an analogy in the way in which a Department of Justice regulation includes wholesale establishments within the scope of places of public accommodation unless they sell exclusively to other businesses and not to individuals.\(^\text{463}\) To the extent that the wholesaler does sell to an individual, it is governed by the ADA. The court concluded that therefore, "the offering of disability policies on a discounted rate solely to a business is not a service or good offered by a place of public accommodation."\(^\text{464}\)

b. Goods and Services

In a second level attack on the three-judge panel's opinion, the *en banc* majority held that the contents or terms of an insurance product are not governed by Title III.\(^\text{465}\) Again referring to Department of Justice regulations, the court found a general regulation directed to accessibility of goods to be persuasive. That regulation states:

The purpose of the ADA's public accommodations requirements is to ensure accessibility to the goods offered by a public accommodation,

\(^{459}\) Parker, 121 F.3d at 1010.

\(^{460}\) 59 F.3d 580 (6th Cir. 1995).

\(^{461}\) Id. at 583.

\(^{462}\) Id. relying on 28 C.F.R. § 36.104 (1991) which provides that a place of public accommodation means a facility and defines facility as "all or any portion of buildings, structures, sites, complexes, equipment, rolling stock or other conveyances, roads, walks, passageways, parking lots, or other real or personal property . . ." and cited in Parker, 121 F.3d at 1011.

\(^{463}\) Parker, 121 F.3d at 1011-12, citing 28 C.F.R. pt. 36 App. B. at 604 (1996).

\(^{464}\) Parker, 121 F.3d at 1012. This conclusion and its supporting rationale is criticized by the dissent.

\(^{465}\) Id. at 1012.
not to alter the nature or mix of goods that the public accommodation has typically provided. In other words, a bookstore, for example, must make its facilities and sales operations accessible to individuals with disabilities, but is not required to stock Brailled or large print books.466

The language of Title V which is directed to the matter of insurance (and which was extensively analyzed by the district court, especially with regard to its safe harbor and subterfuge provisions) was merely noted by the Sixth Circuit as a secondary citation to the DOJ regulation.467

The en banc majority held, "Title IV [sic] does not address the contents of a long-term disability plan offered by an employer because it is not a place of public accommodation."468 Yet the court recognized, in a footnote, that in apparent contradiction to its holding, the Department of Justice's Technical Assistance Manual applies Title III to the contents of insurance products.469 Interestingly, the language of the Technical Assistance Manual largely tracks the provisions of Title V of the ADA addressed to insurance, including the safe harbor provision. The court noted, "As this interpretation is inconsistent with its regulations and the statutory text of Title IV, we decline to adopt it."470

The Sixth Circuit en banc majority also rejected the decision of the First Circuit in Carparts,471 which the three-judge panel had found persuasive. The First Circuit had held that the provider of an employer-provided health benefit plan which placed a cap on AIDS related illnesses, but not other physical illnesses, was a place of public accommodation which may be in violation of the ADA. The First Circuit had reviewed the definition of public accommodation in 42 USC § 12181(7) and concluded that its plain meaning included "providers of services which do not require a person to physically enter an actual physical structure."472

The en banc majority derived from 42 USC § 12181(7) a plain meaning directly opposite that derived from the statute by the panel and the First Circuit. The majority rejected the First Circuit's plainly-derived meaning as a violation of the canon of statutory construction noscitur a sociis, which states that the meaning of ambiguous terms should be ascertained by reference to surrounding words or phrases. Because the majority found the language of the statute so clear, it did not resort to consultation of legislative history.473 The

466Id. (quoting the Department of Justice, 28 C.F.R. pt. 36, App. B at 630).
467Id.
468Id. at 1013. The court must mean to refer to Title V, not Title IV.
469Parker, 121 F.3d at 1012 n.5 (citing DOJ TECHNICAL ASSISTANCE MANUAL § III-3.11000, reprinted in AMERICANS WITH DISABILITIES ACT MANUAL (BNA) at 90:0917).
470Id. (citations omitted).
47137 F.3d 12.
472Parker, 121 F.3d at 1013 (citing Carparts). The three-judge panel had agreed that this was the plain meaning of the statute.
473Id. at 1014-15. The three-judge panel had to resort to legislative history in its
court held that "the provision of a long-term disability plan by an employer and administered by an insurance company does not fall within the purview of Title III."

C. Disparity Between Mental and Physical Disability Benefits

At this point in its opinion the en banc majority tied up loose ends. First, it determined that the district court was correct in dismissing Parker's employer, Schering-Plough, from the Title III claim. The court pointed out that complaints about discriminatory employment practices are within the scope of Title I, not Title III.

construction of the safe harbor and subterfuge provisions of Title V. Title V became relevant only when the insurance product was found to be within the definition of place of public accommodation under Title III. Because the majority found that an insurance product was not a place of public accommodation under Title III, it did not have to consider the terms of Title V in reaching its decision. However, the majority provided an analytical footnote related to Title V:

Title IV [sic] and its accompanying regulations only require that an insurance policy offered by a place of public accommodation be consistent with state law and not a subterfuge to evade the purposes of the ADA to fall within the safe harbor provision. However, it is the opinion of both the Department of Justice and the Equal Employment Opportunity Commission that disparities in insurance policies must be supported by sound actuarial principles.

The discrepancy between the statute, the regulations, and the agency interpretations is due to Congress' failure to define the term "subterfuge" in Title IV [sic] of the ADA. The EEOC and the Justice Department, in certain writings, have expressed the view that, in order for a policy to not be a subterfuge, it must be based on sound actuarial principles. This definition is inconsistent with the Supreme Court's definition of the term subterfuge contained in the Age Discrimination in Employment Act... [which requires] a specific intent to discriminate.

We leave the resolution of the proper definition of subterfuge in Title IV [sic] for another day because we conclude that a long-term disability plan provided by an employer is not covered by Title III; the safe harbor provision is, therefore, not implicated.

Parker, 121 F.3d at 1013 n.7 (citations omitted).

474 Id. at 1014.

475 Id. at 1008-09. The three-judge panel had reversed the district court's dismissal of Schering-Plough and remanded the question of whether an employer who provides, and perhaps partly administers, an employee insurance plan is a proper Title III defendant.

476 Id. at 1014. The majority recognized EEOC regulations and case law which prohibited discrimination against disabled persons in benefit plans such as health insurance but did not comment upon them except in a footnote elaborating upon a district court decision which found that "it would make no sense to construe Title III as including employment practices within its scope. Indeed to do so might wreak havoc with the careful balance that Congress attempted to strike in Title I between the rights of employers and the rights of workers with disabilities." Parker, 121 F.3d at 1015 n.12 (quoting Motzin v. Trustees of Boston Univ. 938 F. Supp. 983, 996 (D. Mass. 1996)).
The court then went on to decide a question which had not been fully discussed by either the district court or the Sixth Circuit three-judge panel. The issue was raised by defendants before the panel as an alternative argument asserting that "the Disabilities Act does not protect against differentiation between different groups of disabled persons, only against discrimination against the disabled versus the non-disabled." While it is clear that resolution of this issue was not necessary to the disposition of this case, the *en banc* majority unequivocally stated:

The disparity in benefits provided in the policy at issue is also not prohibited by the ADA because the ADA does not mandate equality between individuals with different disabilities. Rather the ADA prohibits discrimination between the disabled and the non-disabled; specifically, the ADA mandates that the owners, lessors, and operators of public accommodations provide equal access to the disabled and the non-disabled. Because all employees at Schering-Plough, whether disabled or not, received the same access to the long-term disability plan, neither the defendants nor the plan discriminated between the disabled and the able bodied.

In support of this declaration, the court drew upon several cases interpreting the Rehabilitation Act, including *EEOC v. CNA Insurance Cos.*, which, like

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477 *Parker*, 99 F.3d 181 at 194.

478 *Parker*, 121 F.3d at 1015-16.

479 One of the cases, *Modderno v. King*, 82 F.3d 1059 (D.C. Cir. 1996), held a Foreign Service Benefit Plan which limited mental health benefits to a lifetime limit of $75,000 without parallel limits for physical illnesses, was not a violation of the Rehabilitation Act. This holding was based on the reasoning that across-the-board limits on one type of illness were authorized by the Supreme Court's opinion in *Alexander v. Choate*, 469 U.S. 287 (1985), and that, therefore, partial limits was permissible. *Id.* at 1061-62.

The three-judge panel cited *Modderno* for a much narrower proposition: that the coverage limitations at issue in the case fell within the safe harbor provision of the ADA but were not subject to the subterfuge exception because they were adopted before the ADA was enacted. *See Parker*, 99 F.3d at 191-92. The majority agreed "[t]he court in *Modderno* also held that the cap on mental health benefits under the plan would not constitute a subterfuge under Title IV of the ADA which applies to the Rehabilitation Act," *Parker*, 121 F.3d at 1017 n.14. The court did not explain its conclusion.

480 *F.3d 1039* (7th Cir. 1996). This case is particularly relevant for two reasons. First, as it addresses issues very similar to those presented in *Parker* and *Carparts* it illuminates the split between the circuits.

Second, it took into account a proposed amendment to the Health Insurance Portability and Accountability Act of 1996 which had been defeated before that Act's passage. The proposed amendment would have required mental and physical illnesses to receive the same coverage. The Seventh Circuit took the defeat of the proposed amendment to mean that "the issue of parity among physical and mental health benefits is one that is still in the legislative arena." *Id.* at 1044. What the Seventh Circuit could not have known was that a mental health amendment would soon be enacted. For further discussion of *EEOC v. CNA Ins.*, see notes 247-56 infra and accompanying text.

The court also cited *Krauel v. Iowa Methodist Med. Ctr.*, 95 F.3d 674 (8th Cir. 1996),
Parker, involved long-term disability insurance benefits. The majority aligned itself with the courts that hold that if the identical policy is offered to all employees there is no discrimination under the ADA even if there is disparate impact on people with disabilities.

The same policy is provided to all employees who, when they receive it, are not disabled but working. The fact that some may become disabled for different reasons does not amount to discrimination in providing the policy. The ADA simply does not mandate equality between individuals with different disabilities. Rather the ADA, like the Rehabilitation Act, prohibits discrimination between the disabled and the non-disabled. 461

This section of the en banc majority's opinion is particularly interesting insófar as it takes into account the impact of The Mental Health Parity Act of 1996 (MHPA).462 An amendment to the Health Insurance Portability and Accountability Act,463 the MHPA was enacted after all the cases cited in Parker were decided, but before Parker was itself was decided.464 This Act strives to achieve parity between mental or nervous and medical or surgical benefits: a health insurance policy does not impose annual or lifetime benefits on physical health insurance benefits, it must not do so for mental health benefits. The majority, together with defendants and some amicus curiae, took enactment of the MHPA to be evidence that the ADA did not generally mandate parity between mental and physical benefits. On the other hand, the majority emphasized that the MHPA could not have helped Parker.465 "[I]t appears that Congress did not believe the necessity for parity between mental and physical disabilities in long-term disability plans was sufficiently compelling to include
them within the purview of the Act." The distinction between health insurance benefits and long-term disability benefits has become significant because of the majority's reasoning in *Parker*.

4. United States Court of Appeals for the Sixth Circuit—En Banc Dissents

Five members of the *en banc* Sixth Circuit dissented in two opinions. One was written by Judge Merritt, who had written the decision for the three-judge panel. He was joined by Chief Judge Martin and Judges Moore, Daugherty and Cole. The dissents show that five judges of the Sixth Circuit adopt the view of *Carparts*, *Baker*, *Sharrow* and *Kotev* that the plain meaning of the term public accommodation extends beyond physical structures.

Chief Judge Martin dissented in order to emphasize two points of disagreement with the majority. First, he believed the majority incorrectly interpreted *Stoutenborough*, an opinion he wrote. Second, he believed the majority's opinion on the Title III claim conflicted with clear congressional intent.

Chief Judge Martin's dissent criticized the majority's reliance on *Stoutenborough* to reach the conclusion that Title III is limited to physical structures. Indeed the opinion in *Stoutenborough* stated: "plaintiffs' argument that the prohibitions of Title III are not solely limited to 'places' of public accommodation contravenes the plain language of the statute." However, Chief Judge Martin pointed out the statement was made in the context of determining whether the defendants fell within one of the twelve categories which Title III sets forth to define public accommodation. Because television broadcast of football games does not appear among the categories included within the definition of public accommodations, defendants were not governed by Title III. In contrast, the *Parker* case involves insurance. Title III does include insurance offices within the categories of public accommodation. Consequently, since they are specifically mentioned by the plain language of the statute, the defendants in *Parker* should be governed by Title III.

Judge Martin's dissent further criticized the majority's limitation of Title III to physical structures as inconsistent with the better-reasoned First Circuit decision in *Carparts* and as "completely at odds with clear congressional

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486 *Parker*, 121 F.3d at 1018.
487 *Id*. at 1019 (Martin, C.J., dissenting).
488 *Stoutenborough*, 59 F.3d 580, at 583.
490 *Stoutenborough*, 59 F.3d at 583.
492 *Parker*, 121 F.3d at 1019-20 (Martin, C.J., dissenting).
By limiting Title III’s application to physical structures, the majority deprives disabled persons of the “unprecedented freedom” that would have otherwise been offered to them by technological advances, particularly through communications media. This dissent concluded that a contradictory consequence of the majority’s opinion will be that “[a]s the modern economy increases the percentage of goods and services available through a marketplace that does not consist of physical structures, the protections of Title III will become increasingly diluted.”

The second dissent was written by Judge Merritt. He began by emphasizing agreement with the three-judge panel’s opinion that as a matter of clear statutory language Title III applies to employer-sponsored insurance plans. He pointed out that because the majority opinion conflicts with decisions in other circuits, an “unnecessary conflict between these two views will now have to be resolved by the Supreme Court.”

Judge Merritt’s dissent focused primarily on the illogical consequences of the majority’s holding, both in terms of policy and of statutory interpretation. For example, if the ADA does not cover employer-sponsored plans, why does Title V under some conditions provide a safe harbor for insurance companies? Judge Merritt’s dissent acknowledges the fact that the vast majority of people who have health and disability insurance receive it as a benefit of employment and demonstrates the belief that Congress would not have intended the ADA to provide protection only to those who can afford to independently purchase health and disability insurance. Evidence that congressional intent was to include employer-sponsored plans was provided by reference to Senate and House committee reports which clarify the conditions under which limitations on coverage based on classification of risk are permissible and to EEOC and DOJ views that employer group health insurance is covered by the ADA.
Furthermore, this dissent found it to be bad policy to make applicability of Title III turn on whether a disabled person obtained insurance coverage from her employer or whether she walked into an insurance office and purchased it. Finally, this dissent pointed out that extending Title III to employer-provided plans would not necessarily require equivalent benefits for mental and physical disabilities. The extension would only require that the distinction be based on sound actuarial principles and bona fide risk classification.

D. Analysis of Title III Issues

1. Ambiguity of the General Rule of Title III

Whether an insurer of employer-provided long-term disability insurance is governed by the requirements of Title III of the ADA must be determined by the language of the statute. The general rule of Title III is: "No individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation by any person who owns, leases (or leases to), or operates a place of public accommodation." The general rule prohibits denial of participation, as well as participation in unequal benefit. When the statute uses the term individual or class of individuals, it "refers to the clients or customers of the covered public accommodation that enters into the contractual, licensing or other arrangement."

The simplest meaning of the general rule is that one who operates a place of public accommodation may not discriminate in providing persons with disabilities access to the goods and services it offers. Clearly the first part of the general rule states that individuals with disabilities must enjoy full access not only to physical structures (facilities) but also to goods, services and advantages. If the statute ended there, it would be clear that an expansive reading of the scope of Title III would be unambiguously correct and the limitation of the protection of Title III to access to physical structure would be clearly incorrect.

However, the general rule contains language that it is the goods and services of any place of public accommodation to which full and equal enjoyment must be assured. It is here that an ambiguity sets in. The use of the word place can be understood as a convenient way in which to convey the concept that the general rule applies to all different kinds of businesses or services that interact

501 Id. at 1020.
with the general public. Alternatively, use of the word place can be understood to mean that the prohibition of the general rule is in some way limited to apply only to physical structures. If place means only physical structures, then it can be argued that a public accommodation is only governed by the general rule when it interacts with a disabled person at some facility or physical place.

What is a place of public accommodation? The term place of public accommodation is not defined by the statute. Instead the term public accommodation is defined. The definition of public accommodation is divided into categories or types of public accommodations such as those that provide food, entertainment, shopping, recreation, education, or services. Each category includes illustrative examples. Included in the recreation category of public accommodation are parks, zoos, and amusement parks. Included in the service category are offices of accountants, lawyers, insurance offices, and travel services. In all, over thirty specific private entities, and similar entities, are considered public accommodations for purposes of this subchapter if their operations affect commerce.

The definition of public accommodation includes more than physical structures in which a public entity operates. It includes equal access to the goods and services that the entity provides. This must be true as otherwise the statutory definition of public accommodation would have been much more easily (and briefly) written to state: "a public accommodation is a physical structure in which recreation, entertainment, or services are offered to the public."

Yet some courts have read the definition as merely a list of types of facilities or physical structures. This construction is hard to defend given the ease with which Congress could have utilized language stating that Title III is limited to physical structures. This narrow definition also fails to recognize that other terms are used in the definition, including establishment and service. It seems to be a strained interpretation because a separate section in Title III, and supporting regulations, address the problem of architectural barriers. Further, it is hard to see how else to express the various examples of public accommodations except with the word place. Even if the limiting interpretation is possible, so is the expansive interpretation. Again, the result is ambiguity.

Because the general rule refers not to any public accommodation, but to any place of public accommodation, at least one court reasoned that a disabled person must only be provided barrier-free access to the physical structure which a public accommodation operates. In Pappas, the court agreed that insurance offices are places of public accommodation to which Title III applies,

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but found that the claim was invalid because there was no nexus between the alleged discrimination and the public accommodation.\footnote{Id. at 620. See also, supra notes 367-76 and accompanying text.}

Other courts have held that the inclusion of the word place means the general rule requires non-discriminatory access to goods and services only when the disabled person presents himself at the physical structure at which the public accommodation operates. This appears to be the holding that Judge Kennedy, writing for the \textit{en banc} majority, was defending in \textit{Parker}, when she noted in a footnote that:

Judge Merritt's dissent suggests that our opinion concludes that Parker's disability plan obtained through her employer is not covered by Title III because she physically did not access her policy from MetLife's insurance office. We have not so held. The policy Parker obtained is not covered by Title III because Title III covers only physical places. We have expressed no opinion as to whether a plaintiff must physically enter a public accommodation to bring suit under Title III as opposed to merely accessing, by some other means, a service or good provided by public accommodation.\footnote{Parker, 121 F.3d at 1011 n.3.}

This assertion stands in at least partial contrast to the main body of the opinion where Judge Kennedy wrote:

the good that plaintiff seeks [long-term disability insurance] is not offered by a place of public accommodation. The public cannot enter the office of MetLife or Schering-Plough and obtain the long-term disability policy that plaintiff obtained. Parker did not access her policy from MetLife's insurance office. Rather, she obtained her benefits through her employer. There is, thus, no nexus between the disparity in benefits and the services which MetLife offers to the public from its insurance office.\footnote{Id. at 1011.}

Obviously, MetLife does offer long-term disability insurance from insurance offices. Apparently, if Ms. Parker had walked into an office and privately purchased the insurance, she would have established the nexus Judge Kennedy requires for creation of Title III protection from discrimination. It is unclear what other conduct would have been sufficient, especially because the nexus language comes directly from \textit{Pappas}, in which the holding clearly limits Title III to physical structures.

A slightly different rationale for the holding appears in another part of the \textit{Parker en banc} majority opinion.

While we agree that an insurance office is a public accommodation ... plaintiff did not seek the goods and services of an insurance office. Rather Parker accessed a benefit plan provided by her private

\footnote{Id. at 620. See also, supra notes 367-76 and accompanying text.}

\footnote{Parker, 121 F.3d at 1011 n.3.}

\footnote{Id. at 1011.}
employer and issued by MetLife. A benefit plan offered by an employer is not a good offered by a place of public accommodation.\(^{513}\)

This reasoning allows insurers to avoid all the requirements of Title III by passing the insurance through a third party, the employer. The reasoning supports, and possibly creates, a kind of subterfuge not sanctioned by the ADA.

When this reasoning is viewed as expressing the plain meaning of the statute, rather than a resolution of an ambiguity in the statute, elaboration or discussion comes to a halt. For example in Parker, the *en banc* majority held that the plain meaning of Title III did not allow plaintiff to proceed against the insurer because it was not a place of public accommodation. The opinion added, "We have not referred to legislative history in our discussion of this issue because, where the statutory meaning is clear, we do not resort to legislative history."\(^{514}\)

On the other hand, surely the ADA's statutory purposes, duly enacted with the substantive provisions of the Act, are highly relevant to its enforcement. In terms of authoritativeness, this expression of intent is several cuts above legislative history. The court's narrow interpretation is contrary to the articulated statutory purposes of the ADA. Instead, the statutory purposes of the ADA clearly intend for Title III to be applied broadly.

Other courts have not placed emphasis on the word place, but simply interpreted the general rule in light of an expansive definition of public accommodation. For example, in Carparts, the First Circuit held that any ambiguity, properly placed in context, had to be resolved in the broader sense and that to rule otherwise would frustrate congressional intent.\(^{515}\) The same interpretation was reached in Kotev and Sharrow.\(^{516}\)

A great deal of the ambiguity that appears when one switches from the substantive section of the statute to the definitional section of statute dissolves if the rule and the definition are tied together to provide guidance in a specific instance. One might hypothetically merge the two sections in the following way:

No individual shall be discriminated against on the basis of a disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of an insurance office or

\(^{513}\)Id. at 1010.

\(^{514}\)Id. at 1014 n.10. This illustrates the irony of seeing statutory language as clear: even if the result is contradictory to the legislative intent, the language of the statute will be enforced.

\(^{515}\)37 F.3d 12, 19-20. The court warned that it did not determine more than this threshold issue. For example, the court suggested that the meaning of § 42 U.S.C. § 12182(b)(1)(A)(i)&(ii), which prohibit denial of participation in goods and services and participation in unequal goods and services, is both general and ambiguous. Id. at 19. For further discussion see supra notes 269-79, 377-88 and accompanying text.


other service establishment (place of public accommodation) by any
person who owns, leases (or leases to), or operates an insurance office
or other service establishment (place of public accommodation).

Placing the definition and the rule together in this way makes clear that the
general rule is directed at the conduct of persons toward disabled clients or
customers during operation of a public facility and that the non-discrimination
prohibition is directed toward the goods and services which constitute the
business, not the office or structure from which the entity operates. Note that
the prohibition takes effect if the person owns or operates a place of public
accommodation, not the place at which the disabled individual has presented
himself.

Confining the protections of the statute to those who enter a physical
structure is to underestimate the power of language to define. It is easy to select
a term for, and write a definition that identifies, physical structures. The
Department of Justice did so in the definition of facility, which means "any
portion of buildings, structures, sites, complexes, equipment . . . or other real
or personal property, including the site where the building, structure . . . is
located." That Congress chose other terms which in common parlance have
a broader meaning should be judicially respected.

It is interesting to see how three courts tried to decipher the meaning of place
of public accommodation by reference to common law rules of construction.
The en banc Parker majority understood the plain meaning of public
accommodation was directly opposite to the understanding of the three-judge
panel and the First Circuit. The en banc Parker majority rejected the First
Circuit's plainly-derived meaning as a violation of the canon of statutory
construction noscitur a sociis, which states that the meaning of ambiguous terms
should be ascertained by reference to surrounding words or phrases. With
respect to the very same statute, the Sixth Circuit three-judge panel accused the
Western District of Tennessee of ignoring a Supreme Court rule of statutory
construction which requires interpretation of language in a way that does not
render remaining parts of a statute superfluous. One conclusion is obvious:
this statute has no plain meaning. It is ambiguous.

2. Department of Justice Regulations

The United States Department of Justice is charged with creating regulations
governing Title III. The regulations it promulgated include a restatement of the
general rule.

No individual shall be discriminated against on the basis of disability
in the full and equal enjoyment of the goods, services, facilities,


519 Along these lines the Kotev court wondered "why insurers would need [the] 'safe
harbor' provision [of Title V] if insurers could never be liable under Title III for conduct
such as the discriminatory denial of insurance coverage." 927 F. Supp. 1316, 1322.
privileges, advantages or accommodation of any place of public accommodation by any private entity who owns, leases (or leases to), or operates a place of public accommodation.\footnote{28 C.F.R. \S 36.201(a).}

This regulation is nearly identical to the general rule of the statute, except the regulation replaces the word person with the term private entity. Because the regulations define private entity to mean "a person or entity other than a public entity,"\footnote{28 C.F.R. \S 36.104.} the change is not significant for present purposes. Any ambiguity that lies in the statute is continued in the regulations.

The regulations, like the statute, define public accommodation, but give it a different meaning: "Public accommodation means a private entity that owns, leases (or leases to) or operates a place of public accommodation."\footnote{Id.} The regulations also define place of public accommodation, giving to that term the definition the statute provides for a public accommodation.\footnote{Again, tying the general rule and a specific example from the definition section shows that the effect of this small change is to make even clearer that an expansive reading of the rule is intended. So one might hypothetically link the two sections to say: No individual shall be discriminated against on the basis of a disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of an insurance office or other service establishment (place of public accommodation) by any insurance company (private entity) who owns, leases (or leases to), or operates an insurance office or other service establishment (place of public accommodation). This general rule is directed at private entities who operate a public facility, but the non-discrimination prohibition is directed toward the goods and services which constitute the business, not the office or structure from which the entity operates.}

The Department of Justice Regulations must be recognized to reflect an expansive reading of Title III, and not to limit its prohibitions to instances where the defendant operates from a physical structure. However, courts that view the plain language of the statute to be more limited decline to adopt the regulations. The \textit{Pappas} court, for instance, drew upon United States Supreme Court authority to the effect that an administrative regulation would only be deferred to where "Congress has not expressed its intent with respect to the question and then only if the administrative interpretation is reasonable."\footnote{\textit{Pappas}, 861 F. Supp. 616, 620.} The \textit{Pappas} court found that because the regulation was inconsistent with the plain meaning of the statute, it would not be followed.

The \textit{Parker en banc} majority acknowledged that the Department of Justice Technical Assistance Manual interprets Title III to include prohibition against discrimination in the content of insurance contracts, but declined to adopt that interpretation, saying it is "inconsistent with [Department of Justice] regula-
tions and the statutory text of Title IV [sic]." The Department of Justice regulation with which the majority says the Technical Assistance Manual is inconsistent is the definition of wholesale establishments. This definition appears, not in the regulations themselves, but in commentary which appears in an appendix to the regulations. No mention is made of other Department of Justice regulations other than those related to Title V.

On the other hand, the Kotev court, which found Title III to have a more expansive scope, found support in Department of Justice regulations. This court found persuasive support for the more expansive reading of Title III in the same document the Parker en banc majority found support for a narrower reading: "The Department of Justice further notes that 'life and health insurance are the areas where the regulation will have its greatest application.'... This commentary is consistent with the legislative history" of the ADA.

3. Department of Justice Technical Assistance Manual

The Department of Justice Technical Assistance Manual demonstrates that the Department of Justice understands Title III to extend beyond assuring access to physical structures.

Insurance offices are places of public accommodation and, as such, may not discriminate on the basis of disability in the sale of insurance contracts or in the terms or conditions of the insurance contracts they offer.

The broad range of title III obligations relating to "places of public accommodation" must be met by entities that the Department of Justice regulation labels as "public accommodations." This Technical Guidance says insurance offices (which are undeniably places of public accommodation because they are included as an example in the service category of the statutory definition of public accommodation) must not discriminate in the terms and conditions of insurance contracts. It also says that

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525 Parker, 121 F.3d 1006, 1012 n.5. The court must intend to refer to Title V.

526 Id. at 1011.


528 Kotev, 927 F. Supp. 1316, 1322-23.

529 Id. at 1323.

530 U.S. Dept. of Justice, THE AMERICANS WITH DISABILITIES ACT TITLE III TECHNICAL ASSISTANCE MANUAL: COVERING PUBLIC ACCOMMODATIONS AND COMMERCIAL FACILITIES (Nov. 1993) at § III-3.11000. The section explains that all types of insurance are covered by Title III.

531 Id. at § III-1.2000. The entities referred to are the same as those referred to in the statute and regulation. The Department of Justice considers places of public accommodation to have a broad range of Title III obligations—not simply the obligation to provide access.
insurance offices are subject to a broad range of Title III obligations. So at least it is clear that the Department of Justice believes that a person with a disability who enters an insurance office must be provided non-discriminatory insurance contracts, not simply an accessible entrance to the insurance office.

It can possibly be argued that these sections still do not clarify whether a disabled person who seeks insurance by telephone or through his employer also is entitled to a non-discriminatory contract. But surely it must be so. Otherwise, to secure the protections of Title III, millions of persons with disabilities would have to make a trek to the physical space in which the insurer's representative sits. This has more than one element of absurdity to it, especially since most insurance contracts are not drafted or even signed in insurance offices. They are drafted in the insurers' home office and transmitted to the insured by mail. The legal work of an insurance contract is done by an employee of the insurer at a central location that may be hundreds of miles from a disabled insured. Surely the validity of the contract terms cannot turn on whether the insured showed up at a local office. Also it would be shockingly poor drafting if this important threshold requirement were not clearly and specifically set forth in the statute.

A further absurdity appears when one thinks that this would mean that insurance companies would have to have two sets of insurance contracts to cover individuals with similar actuarial characteristics and risks—one for people with a disability who receive the insurance by telephone or as a benefit of employment, and one for people with a disability who show up at an insurance office. It would be permissible to discriminate against the former but not the latter. Most non-elderly Americans would have the discriminatory form of insurance because the majority of insured Americans receive their insurance as a benefit of employment. Only those wealthy enough to afford to buy insurance privately, and healthy enough to obtain it, would be covered by the ADA, providing they were knowledgeable enough and ambulatory enough to present themselves at the insurer's business facility. Title III, a comprehensive, remedial, civil rights statute was not written or intended to exclude the majority of Americans and those who are most severely in need of its protections.

532 This section warns that because of the nature of insurance, disparities in coverage of disabled persons are permitted so long as the disparities are justified by the use of sound actuarial principles:

Because of the nature of the insurance business ... consideration of disability in the sale of insurance contracts does not always constitute "discrimination." An insurer or other public accommodation may underwrite, classify, or administer risks that are based on or not inconsistent with State law, provided that such practices are not used to evade the purposes of the ADA [and are] ... based on sound actuarial principles or ... related to actual or legitimate actuarial considerations ...

Id. at § III-3.11000.

The section also explains that all types of insurance, including disability insurance, are covered by Title III. This part of the technical assistance tracks the language and the policy of Title V of the ADA.
4. Resolving the Ambiguity

The preceding sections demonstrate that an ambiguity exists in Title III of the ADA with respect to whether its prohibitions are limited to physical structures. When an ambiguity exists it is appropriate to consider the purposes of the Act.

In the ADA, Congress intended to address the major areas of discrimination faced day-to-day by the 43,000,000 Americans with physical or mental disabilities. Congress found that discrimination against individuals with a disability persists in such areas as employment and health services and that those who are disabled continually encounter various forms of discrimination in benefits and jobs. Congress recognized census data which showed individuals with a disability occupy inferior status vocationally and economically. Because the general population is aging, the number of individuals with physical and mental disabilities will increase. Congress invoked the sweep of its authority to achieve the purpose of providing a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities, including clear, strong, consistent, and enforceable standards.

To the extent that an ambiguity exists as to the scope of Title III, the ambiguity must be resolved to achieve the purposes of the Act. An expansive reading of Title III will achieve the congressional purpose of redressing the persistence of discrimination in employment, benefits and health services. Insurers who contract with employers to provide health or disability insurance to employees must be required not to discriminate in the coverage offered. As a result, even individuals with serious, totally debilitating illnesses will have the protection of the ADA. A narrow reading of Title III will frustrate congressional purpose. Americans who develop totally disabling mental illnesses will have no forum in which to challenge the discrimination they experience.

The problem presented by this article is that employees who develop totally disabling mental illnesses usually find that the long-term disability insurance provided by their employers provide inferior benefits for mental disabilities compared to physical disabilities. When they attempt to challenge the disparity by suing their employers under Title I they find that courts usually hold that their disability keeps them from coming within the definition of qualified individual with a disability. Thus, the protections of Title I are unavailable to them. When they attempt to challenge the disparity by suing the insurers under Title III, they are confronted with a split in the circuits. Some individuals are permitted to proceed under Title III. Other individuals are not permitted to proceed because they obtained the insurance through their employers. Because they did not obtain the insurance by walking into an insurance office the protections of Title III are unavailable to them.

53442 U.S.C. § 12101(b).
It is important to note that resolving the threshold issue in favor of application of Title III to insurers of employer-provided benefits does not answer the substantive question of whether the disparity in benefits constitutes discrimination under the ADA. Allowing a disabled person to proceed against the insurer only provides the opportunity to persuade a court that unlawful discrimination exists. Title V of the ADA gives insurers special defenses against such discrimination claims in both Title I and III cases. The defenses do not extend so far as to allow a subterfuge to evade the purposes of the Act. 5

A disability-based distinction in an insurance plan does not violate the ADA if the distinction falls within the safe harbor provision and is not a subterfuge. The meaning of disability-based discrimination, the point at which fair discrimination based on actuarial classification becomes a subterfuge to evade the policy of the ADA and then how to measure subterfuge, have not been clearly identified. These issues have been heavily litigated and subjected to frequent commentary and analysis. 5

VIII. CONCLUSION

Disabling, serious mental illness can have catastrophic economic and social consequences. The individual whose mental disability makes it impossible for him or her to work may be faced with overwhelming medical expenses and simultaneous loss of income. The family of the individual may experience not only economic disaster, but also increased physical illness and familial disharmony.

These facts are exactly the kind that make insurance necessary and attractive. Insurance that provides wage security to a person with a disabling mental illness is most likely to be obtained from the individual's employer as a benefit of employment. Employers are the source of most private (non-governmental) health insurance. Employers are also the source of most private long-term disability insurance, though disability insurance is far less common than health insurance.

Employers must select insurance benefits for their employees in a way that allows for a satisfactory margin of profit. To do otherwise would help no one. However, when most health and disability insurance is selected with an eye on

535 For text of 42 U.S.C. § 12201(c), see supra note 440.

536 For example, the subterfuge provision of the ADA has been closely linked with the subterfuge provision of the ADEA. The question is whether cases decided under the ADEA interpreting the term subterfuge, e.g., Public Employee Retirement System of Ohio v. Betts, 492 U.S. 164 (1989); United Air Lines Inc., v. McMann, 434 U.S. 192 (1977); and McGann v. H & H Music Co., 496 F.2d 401 (5th Cir. 1991), should be authority for interpreting the same term in the ADA. Some commentators argue that the history and structure of the ADA demonstrates a rejection of the earlier cases. See, e.g., Jacobi, supra note 67, at 355-59. (This article also includes an exhaustive collection of cases, articles, and EEOC action). See also Bonnie Poitras Tucker, Insurance and the ADA, 46 DePaul L. REV. 915 (1997); Bilimoria, supra note 28; McFadden, supra note 25.
the bottom line, the scope of coverage may reflect unjustifiable stereotypes and prejudices.

This is the situation for those with mental illnesses in the context of both health insurance and long-term disability insurance coverage. In employer-provided health insurance policies, physical illnesses typically have generous or unlimited lifetime benefit limits—often up to a million dollars. Employer-provided long-term disability insurance for physical disabilities typically provide a benefit of sixty to eighty percent of the insured's salary. But if the illness or disability is classified as mental, health insurance limits are dramatically inferior and long-term disability benefits are often limited to as little as two years. Insofar as these coverage limits are placed on serious mental illnesses, such as organic brain diseases, the disparity of benefits between physical and mental disabilities is the result of lingering stigma, stereotypes, and uninformed views about the treatability of such mental illnesses.

Stigma, stereotypes and uninformed views about individuals with disabilities are the target of the Americans with Disabilities Act. The ADA was intended to assure equality of opportunity, full participation, and economic self-sufficiency of individuals with either physical or mental disabilities. Title I of the ADA prohibits an employer from discriminating against an individual who has a mental or physical disability in the terms, conditions, and privileges of employment. Title III of the ADA prohibits discrimination against an individual who has a mental or physical disability in the full and equal enjoyment of goods and services of any place of public accommodation.

The ADA seems to offer a means by which disparities in employer-provided long-term disability benefits provided for individuals with mental disabilities, compared with physical disabilities, can be evaluated and redressed. However, the ADA has often been interpreted to bar individuals with mental disabilities at the threshold of the Act, never allowing them the opportunity to demonstrate that the disparity is unlawful discrimination. Title I is usually said to be unavailable to an employee with a long-term mental disability because one who has a long-term disability is unable to work and thus is not an otherwise qualified individual with a disability, a status prerequisite to Title I protection. Title III is sometimes said to be unavailable because an insurer who provides insurance through an employer is not a place of public accommodation.

This insulation of both the employer and the insurer makes it virtually impossible for any person with a disabling mental illness to challenge the disparity in employer-provided long-term disability benefits. Thus, individuals who are victims of discrimination based on disabilities are unable to secure the protection of federal law that was enacted for them. This is not the result contemplated by Congress. More important, this result is not required by the language of this remedial statute.

This article has argued that Title I protects individuals in an employment relationship, whether they are applicants, current employees, or former employees. An employee who receives long-term disability insurance as a benefit of employment does not lose the right to challenge the terms of that insurance when he or she develops a serious mental disability. Similarly, Title III prohibits an insurer who contracts with an employer to provide long-term disability benefits to employees from engaging in unlawful discrimination on the basis of serious mental disability. The fact that the insured employee has
not entered a physical structure from which the insurer does business does not deprive the employee of the protections of Title III of the Americans With Disabilities Act.